HOSPITALS

ELEMENTS of the General Hospital
—Revised Edition

Four-Point Study on Financing Care
—Harry Becker

Standardization—Its Impact on Tomorrow
—Malcolm T. MacEachern, M.D.

Comparing Ward and Private Room Costs
—E. Dwight Barnett, M.D.

APRIL • 1952

The Journal of the American Hospital Association

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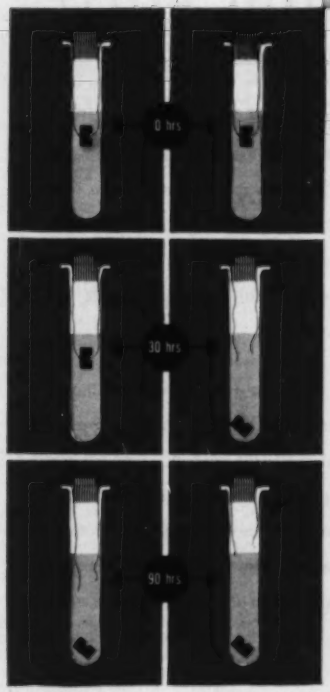

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HOSPITALS

IN THIS ISSUE

APRIL • 1952

The Journal of

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VOLUME 26 NUMBER 4

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54th Annual Convention—September 15-18; Philadelphia.

REGIONAL MEETINGS

Carolinas-Virginias Hospital Conference—April 24-25; Roanoke, Va. (Roanoke Hotel).

Middle Atlantic Hospital Assembly—May 21-23; Atlantic City (Convention Hall).

Mid-West Hospital Association—April 23-25; Kansas City, Mo. (President Hotel and Municipal Auditorium).

Southeastern Hospital Conference — April 16-18; Atlanta (Atlanta Biltmore Hotel).

Tri-State Hospital Assembly—April 28-30; Chicago (Palmer House).

Upper Mid-West Hospital Conference — May 14-16; St. Paul (Lowry and St. Paul hotels).

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Association of Western Hospitals—May 12-15; San Francisco (Civic Auditorium).

STATE MEETINGS

Arkansas—May 5-6; Hot Springs (Arlington Hotel).

Connecticut—May 20; New Haven (Auditorium, Southern New England Telephone Co.).

Idaho—May 27-28; McCall (Shore Lodge, Payette Lakes).

Indiana—June 13; Indianapolis (Lincoln Hotel).

Iowa—April 23; Des Moines (Kirkwood Hotel).

Kansas—November 6-7; Kansas City (Town House).

Maine—June 27-28; Belgrade Lakes (Belgrade Hotel).

Mississippi—October 16-17; Jackson (Heidelberg Hotel).

New Jersey—May 21-23; Atlantic City (Convention Hall).

New Mexico—May 24; Clovis (Clovis Hotel).

New York—May 21-23; Atlantic City (Ritz Carlton Hotel).

North Dakota—April 1; Grand Forks (Dakota Hotel).

Ohio—March 31-April 3; Cleveland (Cleveland Hotel).

Pennsylvania—May 21-23; Atlantic City (Convention Hall).

South Dakota—October 6-7; Rapid City (Alex Johnson Hotel).

Tennessee—May 8-10; Memphis (Peabody Hotel).

Texas—May 20-22; Houston (Shamrock Hotel).

West Virginia—April 24; Roanoke, Va. (Roanoke Hotel).

OTHER MEETINGS

American Medical Association—June 9-13; Chicago (Palmer House).

American Physical Therapy Association—June 23-28; Philadelphia (Bellevue-Stratford Hotel).

Catholic Hospital Association—May 26-29; Cleveland (Public Auditorium).

Catholic Schools of Nursing—May 24-25; Cleveland (Public Auditorium).

International Congress of Physical Medicine—July 14-19; London.

National Association of Clinic Administrators—September 28-October 1; Chicago (Palmer House).

INSTITUTES

(For additional information address Association headquarters, 18 E. Division Street, Chicago 10.)

Institute on Personnel Relations, in conjunction with Southeastern Hospital Conference—April 14-15; Atlanta (Atlanta-Biltmore Hotel).

Institute on Public Relations, in conjunction with Mid-West Hospital Association—April 21-22; Kansas City (President Hotel).

Institute on Operating Room Administration, in conjunction with Tri-State Hospital Assembly—May 1-2; Chicago (Palmer House).

Institute on Credit and Collections, in conjunction with Association of Western Hospitals Assembly—May 7-9; San Francisco (Mark Hopkins Hotel).

(Continued on page 184)

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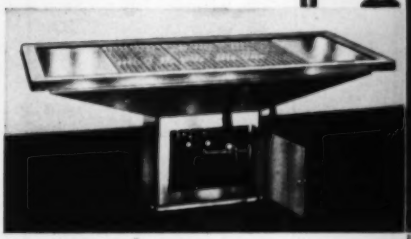

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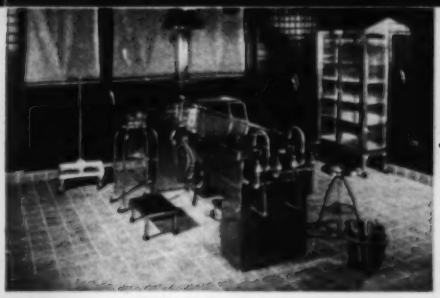

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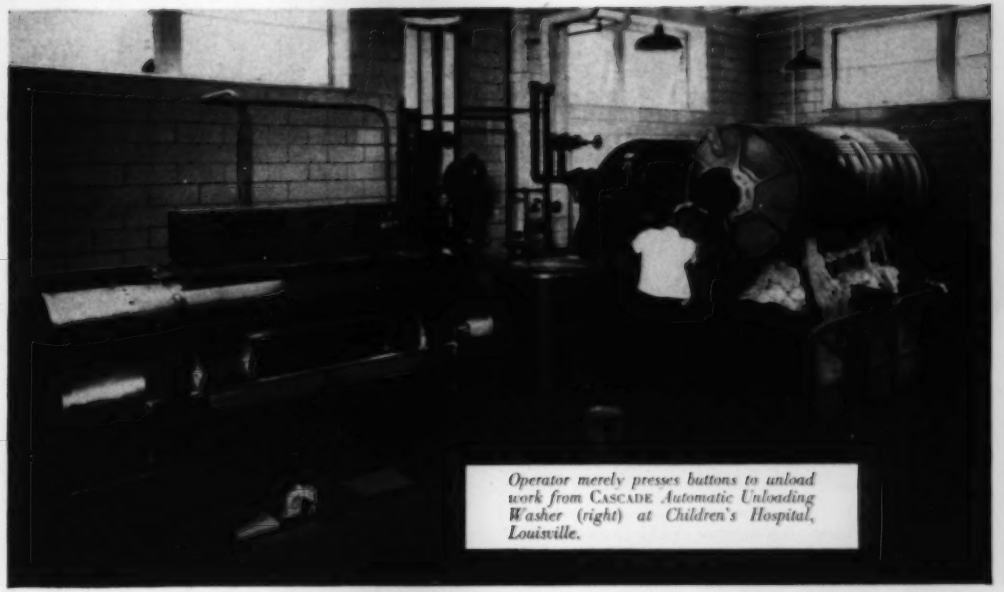

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SPENT ONE DAY last month with 10 of the finest fellows I've met since becoming prexy. Perhaps the fact that none of them was connected with hospitals impressed me, or perhaps it was due to the fact that being president of the A.H.A. didn't impress them. A case of Honor without Profit in the home town. Well, it was a busy day and I was really cut down to size—in fact, once I was told to take a long walk on a short pier. Time after time I was humiliated because of my lack of knowledge of current events outside the hospital field. For instance, I didn't know the answer to this: "If kings ride on Gold, who rides on Silver?" I was told it was the Lone Ranger. Then I felt I was coming to the top when I answered two questions correctly—"What is the operation describing the removal of tonsils?" Tonsillectomy, of course. "What is the operation describing the removal of the appendix? Appendectomy, of course. And then I met my Waterloo. "What is the operation describing the partial removal of the head?" I was soon told, "A hair cut, of course!" and was further told that my M.D. didn't mean Doctor of Medicine but rather—"Mentally Deficient!" We lunched on hamburgers, onions, baked beans, cole slaw, ice cream and cake, and during the meal I took quite a beating. Someone said, "Doctor, they are coming for you," and when I asked who, "Not the Red Coats, but the White Coats with a nice big shiny car, with barred windows and a siren." It was a refreshing day and if you would like to share my joy, just round up 10 twelve-year-olds to take on your son's birthday party for a day in the country. Hospital administrators are stealing too much from the kids for the hospital. It should stop.

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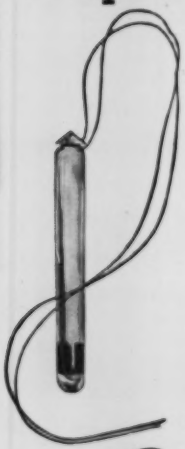

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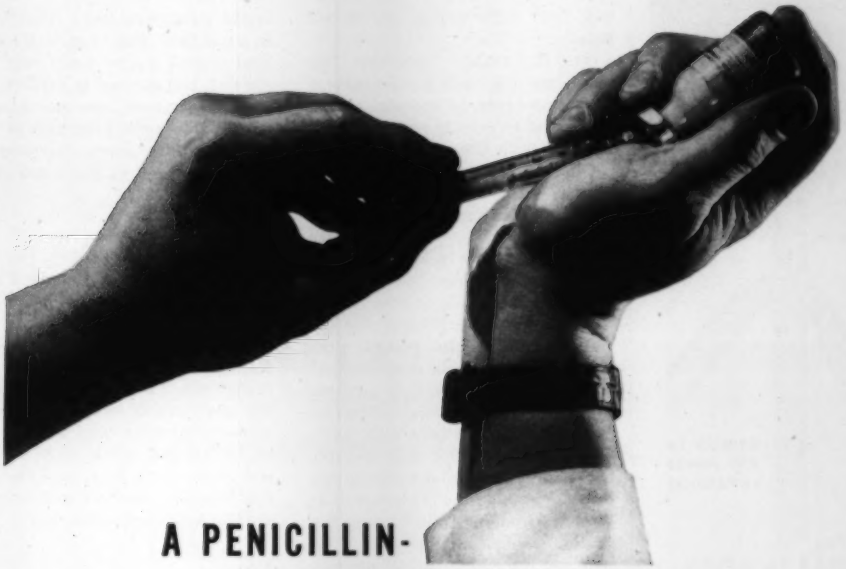
I HAVE BEEN TALKING with some of my friends connected with medical school teaching hospitals, and there seems to be some agreement regarding the cause of reduced occupancy on teaching wards during the past few years. First—and very major—is the effect of prepayment plans when they became a subject for collective bargaining. I have seen the effect of this at home—three of our personnel in the past six months have selected private surgeons for their care. Previously these people would have selected our ward service, but with Blue Cross coverage and medical and surgical benefits, they have elected the private service.

Secondly, more hospital beds have been built outside the large cities, where most medical school hospitals are located. Previously towns without hospitals referred many cases to the university services.

Thirdly, the improved and accelerated specialty training programs have developed many more men to place in the new hospitals outside the cities. In many such places, brain surgery, eye surgery,



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etc., are successfully performed locally.

Fourth, modern medicine has developed the tools to eliminate a goodly portion of hospitalization, as well as to greatly reduce hospital stay with the remainder.

This is having a marked and serious effect on medical education and is a far cry from my own student days when patients were brought distances in Michigan that were greater than the distance from New York City to Ann Arbor.

Looks to me as though it's the responsibility of the medical profession to solve this one. Medical schools need money and patients to carry on. The medical profession is in a position to help with both. I have discussed this with a number of practitioners outside of San Francisco and the response has been the same: "Didn't know the schools needed patients . . . Why, sure we can help . . . Glad you brought it to our attention . . ."

MY COMMENTS a few months ago about farming out roach control brought forth an inquiry why I didn't question the desirability or undesirability of contracting for other services such as: Window washing, wall washing, housekeeping, mimeographing, laundry, painting, general maintenance and public relations.

I won't try to analyze the pros and cons, but would like to refer to a thought put forward by Dr. Jack Masur, chairman of our Council on Hospital Planning and Plant Operation, a few years ago when he said, "All hours of the administrator spent in directing services which could be furnished in some other way as satisfactorily and as cheaply, are hours taken away from patient contact which should be the administrator's major concern." Well, that should set the thought: Our specialty is patient care, not pest control, painting or public relations. They are merely means to an end. Only you can say how best your hospital can secure such services.

IN JANUARY some of the Republican Party Inner Circle met in San Francisco, but your prexy wasn't asked for any advice. Should be hectic from now until November, in a political sense. Let us all pray that neither major party will use the sick and injured to further political objectives. Now that kissing babies has been banished to the political limbo, there does seem to be more interest in the ill and aged.

WE MUST ADMIT we were all wet in California in January. On one trip through Marin County I saw a sign, "Fresh Crab for Sale," and it could very well be fresh for it would have taken a boat to get to the sign and to the front of the restaurant. I'm sure you read of the snowbound streamliner, City of San Francisco—and were proud of the fact that it was an M.D. who was Hero of the Pullmans. Doctors and hospitals are fine assets to have around when one needs them.

HAD A DISCUSSION with our assistant superintendents and we agreed that "precedents" were the administrator's bugbear. Each one related some instance where he or she would have liked not to abide by general policy but they all agreed that to do so would make the administration of general policy untenable. At the same time we decided that a good administrator is capable of breaking a rule where conditions warrant, but that such conditions must never be emotional likes or dislikes, but rather tangible factors which would not prevent administration of an accepted general policy at a later date.

HAVE BEEN TO Florida with Blue Cross; Chicago for Mid-Year meeting; and Phoenix for Arizona Hospital Association meeting. March called for a Joint Commission on Hospital Accreditation meeting in Chicago and the New England Hospital Assembly in Boston. Still don't agree with the fellow who said he would rather be right than be president. It's a lot of fun, lots of work, lots of nice people and a lot of satisfaction.

Anthony J. J. Rourke

Anthony J. J. Rourke, M.D., President
American Hospital Association

a statement on

RIMIFON

the new Roche antituberculous drug

The studies published in the current issues of the American Review of Tuberculosis, Diseases of the Chest and the Sea View Bulletin indicate that Rimifon* (isonicotinic acid hydrazide) is a potent antituberculous agent.

Numerous additional investigations are now under way to obtain further information as to optimal dosage, duration of treatment and incidence and significance of side reactions. The medical profession will be kept informed by means of letters and announcements in medical journals.

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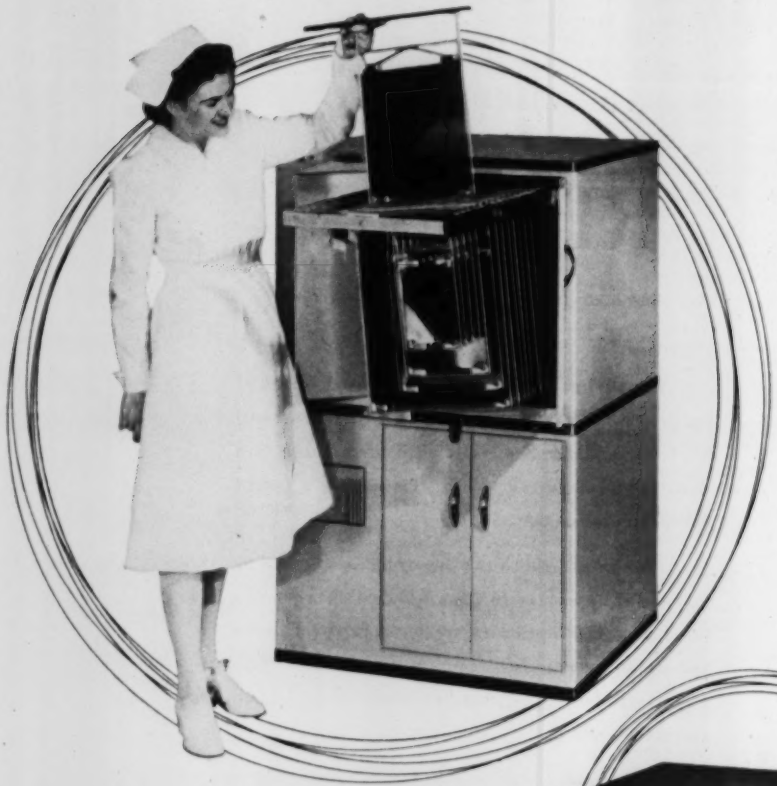

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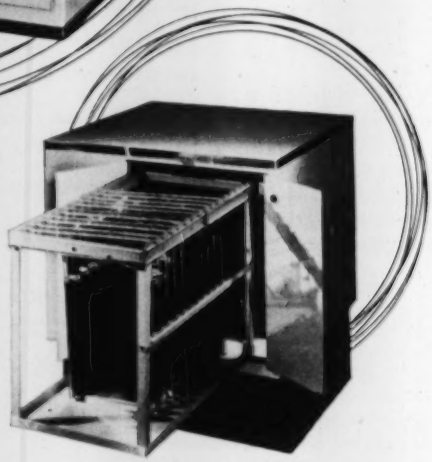

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1. Hazelton Laboratories, Falls Church, Va. Private communication.
2. Nesbit and Lapides. Univ. Michigan Med. Bull. 16, 37-42 (1950).
3. Richardson and Rose. J. Urol. 63, 1113-19 (1950).
4. Robbins, Colby, Sosman and Eyler, Radiology 56, 684-688 (1951).
5. Neuhaus, Christman and Lewis. J. Lab. Clin. Med. 35, 43-9 (1950).

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Male Ward Building, Western State Hospital, Fort Steilacoom, Wash.
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Proper Temperature **—external and internal, hastens recovery of patients.**

St. Joseph-Benton Harbor Memorial Hospital, St. Joseph, Mich.
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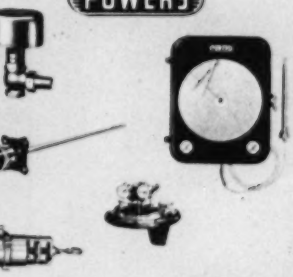
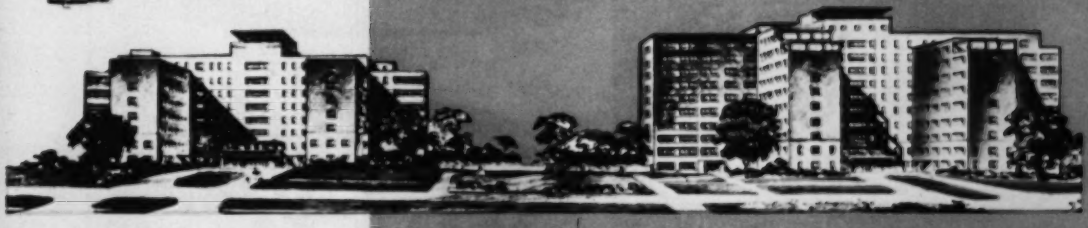


Comanche County Memorial Hospital, Lawton, Okla.
Architect: Paul Harris, Chickasha, Okla.
Paul H. Fesler, Hospital Consultant
Engineers: Carnahan & Thompson, Oklahoma City, Okla.
Contractor: Ray F. Fischer Co.



Veterans Administration Hospital, West Haven, Conn.
Left: 400 bed Tuberculosis Bldg.; *Right:* 500 bed General Medical & Surgical Bldg.
Architects: Curtin and Riley, Boston, Mass.
Engineers: Corps of Army Engrs., Boston District
Contractor: Raisler Corp., New York City

Morristown Memorial Hospital, Morristown, N. J.
Architects: John H. & Wilson C. Ely, Newark, N. J.
Hospital Consultant: Gerhard Hartman, Ph. D., New York City
Mechanical Engineers: Meyer, Strong & Jones, New York City
Contractor: August Aroce & Sons, Inc., Elizabeth, N. J.

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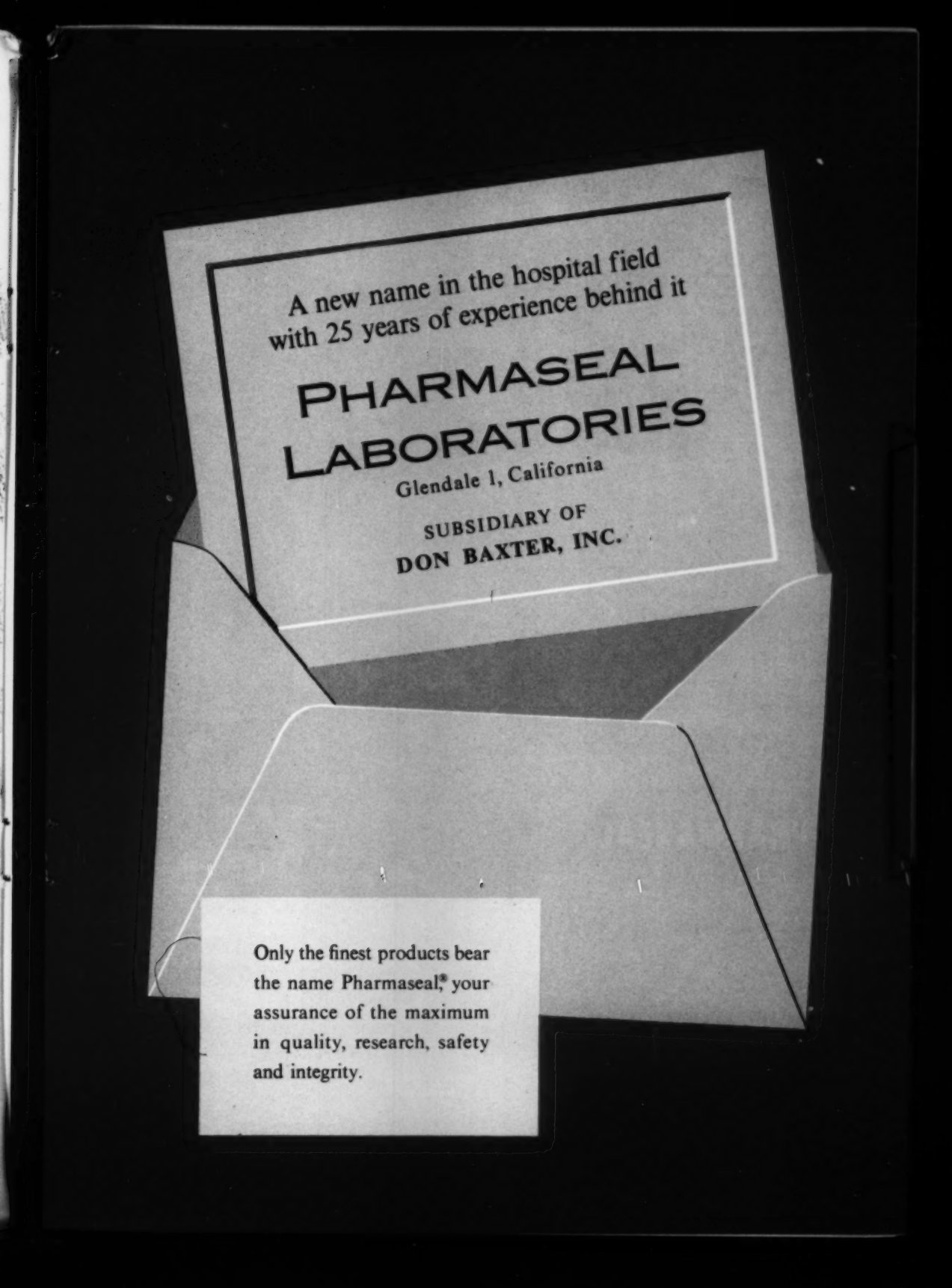
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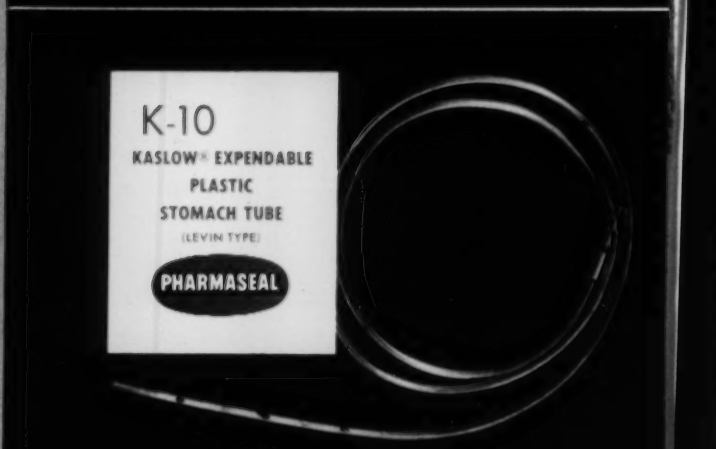

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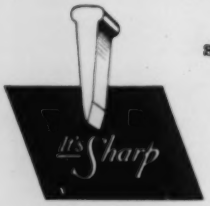

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Operating room nurse aides

Should nurse aides be employed in the operating rooms, and if so, does the hospital become liable?

Many hospitals which are short of nurses have made it a practice to use practical nurses in the operating room. If circumstances warrant it, I see no reason why a properly trained nurse aide could not be so employed.

Considering that the courts hold the surgeon responsible for the conduct of his assistants during an operation, it would seem to be a reasonable practice to use nurse aides in the operating room if the operating surgeon consents to their employment there. It should be remembered, however, that a surgeon is not obliged to accept all persons provided to assist him in his operation.

The hospital is responsible for selecting and providing the most qualified personnel that can be found in the community, but where there is no selection, the hospital must do the best it can with the material available.

Since the surgeon is responsible for the actions of those who assist him in the operating room, I do not see how the employment of nurse aides, with the consent of the surgeon, could increase the liability hazard of the hospital.—DR. CHARLES U. LETOURNEAU.

Medical staff's executive body

What are the functions of the medical staff's executive committee?

The executive committee of the medical staff generally has the folowing duties:

1. To represent the medical staff of the hospital in the consideration of all matters pertaining to the professional aspect of the hospital.
2. To act as liaison between the medical staff and the administration.
3. To maintain general supervision over the medical staff to see that it is fulfilling all its obligations to the patient and the hospital.

In short, the committee is the medical staff's active group that is concerned mostly with medico-administrative matters. For more detailed information, check the following sources:

1. "Manual of Hospital Standardization" of the American College of Surgeons. Pages 12-27 of the 1946 edition.
2. "The Medical Staff in the Hospital" by Thomas R. Ponton. This text is now being revised by me.
3. "Hospital Organization and Management" published by the Physician's Record Co., Chicago. This is my own work.—DR. MALCOLM T. MACEACHERN.

Contaminated linen

What is the usual practice regarding the handling of contaminated linen?

Going by the information I have available and according to material in the American Hospital Association's laundry manual, it seems to be generally felt that the placing of contaminated linen in separate bags sufficiently protects other laundry and personnel.

A possible exception to this could be linen infected by the virus of infectious hepatitis. Studies are being made at this time to determine whether or not a variation in procedure is necessary when handling linen in such cases, and whether or not there is danger of contamination by this micro-organism.—LEONARD P. GOUDY.

Children visitors

It is our understanding that the American Hospital Association has established the policy of prohibiting children under 14 years of age from visiting hospitals. Please confirm or correct our understanding of this matter.

So far as we can determine from the proceedings of the American Hospital Association, there is no official policy concerning the prohibition of children under 14 years of age from visiting patients.

While the policy of the Association on this subject has not been defined, there are many reasons why young children should not be permitted to visit patients in hospitals. The following are a few:

1. Children are natural carriers of infectious agents which could be harmful to patients. Although the child has a natural immunity to certain types of bacteria, adults are susceptible to infection by them.
2. Children tend to be noisy and thus would disturb patients who are in need of much rest.
3. Children usually are curious and they may be attracted to hospital equipment, thereby causing damage to it, or worse, causing harm to themselves.
4. Children sometimes are sensitive to the sufferings of others and may become emotionally upset.
5. The curiosity of children concerning the ailments and deformities may prove embarrassing to some patients.
6. Children sometimes are upset by unfamiliar odors, such as may be present in some hospitals.
7. The presence of children may be a distraction and a handicap to the nursing staff and the personnel employed in the care of the patients.
8. Children frequently require bathroom facilities which are not easily available on adult floors in hospitals.

There are exceptions to these rules, of course. Certain circumstances may make it necessary to permit a child to visit a parent, for instance. But when such visiting is warranted, it is advisable to require that the visits be made outside of visiting hours. This will prevent complaints of discrimination by visitors who have been obliged to leave their children in the waiting room while visiting someone in the hospital. It is advisable also to have the visiting children accompanied by a member of the hospital staff. The purpose of this rule is to protect the patient and the child from injury, and the hospital from liability for injury which may be caused by the child as a result of his own curiosity.—DR. CHARLES U. LETOURNEAU.

Bedding during oxygen therapy

Should special bedding be used when a patient is in an oxygen tent?

Some hospitals substitute cotton blankets for woolen blankets while the patient is in an oxygen tent. There may be some justification for such practice. In addition, it might be advisable to investigate the possibility of using sheets that have been treated in the laundry with flame-retardant compounds.

Bedding that has been treated with such compounds might also be tinted a distinctive color so that it will be used only on the beds of patients receiving oxygen therapy. This may call for a complication of nursing technique that is beyond practical administration, but prob-

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ably it is worth some study if there is a chance that it may prevent loss of life caused by fires in oxygen tents.—ROY HUDENBURG.

Surgeon's scrub nurse

Is it common practice for a hospital to allow a surgeon to supply his own scrub nurse to assist in surgery of his own patients?

The system was in vogue more than 25 years ago, but it was ultimately discarded for many good reasons.

The question to be considered is whether the method of allowing each surgeon to bring his own scrub nurse would be in the best interest of the patient. Current authoritative opinion in surgery and in hospital administration holds that this system would not be in the best interest of the patient.

There also is the question of control by the hospital over the personnel and the equipment in the operating room. The scrub nurse is but one of many assistants who help the surgeon to operate on his patient. While the surgeon is in charge of the operation itself, the entire coordination and organization of the operating room is vested in the operating room supervisor. If the scrub nurse is not under the direct jurisdiction of the operating room supervisor, there is room for friction and improper supervision of the personnel assisting the surgeon. This is not in the patient's interest.

Now it is common for the hospital to supply all the nursing personnel in the hospital, whether this be in the operating room, on the ward, or in the outpatient clinics. Nurses are all employees of the hospital, except the special nurse who is hired specifically by the patient.—DR. CHARLES U. LETOURNEAU.

Stillbirth records

What should be the hospital's procedure on recording a stillbirth?

It is not customary to make out a special chart for a stillbirth. A stillbirth is not considered to be a normal live birth and is recorded separately.

A very complete notation of the circumstances of the stillbirth and an autopsy protocol should be included on the mother's chart where these are available.—DR. CHARLES U. LETOURNEAU.

Records in court

Recently, I, as administrator, was called as a witness in a court case involving a former patient, and my summons specified that I was to bring all records pertaining to this patient. Both the medical record librarian and I were reluctant to remove these records and turn them over to the court, but not being sure of our right to withhold them, we complied with the court order. Did we do the correct thing?

A summons is an order from a court of law to appear before an appointed representative of the court to testify as to facts that might enable the court to make a just decision in a particular dispute.

When the summons specifies that you are to bring with you all records pertaining to the case, you must obey. Your testimony and that of the records in your custody is necessary to further the interest of justice.

Medical records should be released only on a court order. The summons, however, is the court order in this case. It is understood, of course, that both attorneys should be represented when the contents of the records are disclosed.—DR. CHARLES U. LETOURNEAU.

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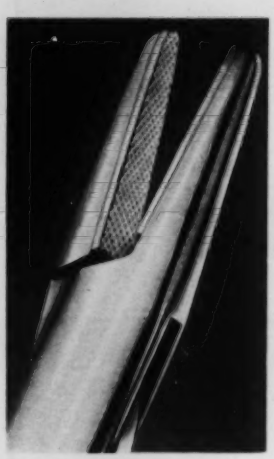

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opinions

ON DETERMINING GENERAL HOSPITAL BED NEEDS

THE HILL-BURTON Act, passed in 1946, set forth certain ratios of general hospital beds to population beyond which the federal government will not provide aid for construction, and these ratios now are used for determining the need for general hospital beds. These limits are 4.5 beds per 1,000 population in states having 12 or more persons per square mile, 5.0 in states having more than 6 and fewer than 12 persons per square mile, and 5.5 in states having 6 or fewer persons per square mile. Since 1946, early ambulation and other factors have shortened the stay of many patients, and there has been much discussion concerning the present validity of the ratios set up in the law.

Five men who have had considerable experience with these ratios give their opinions below, in answer to the question: "In view of early ambulation, the shortened stay of more hospitalized patients and other factors, do you think the recommended ratios of 4.5 to 5.5 general hospital beds per 1,000 population, as set forth in the Hill-Burton Act, are still realistic? If not, what do you suggest as a basis for determining the desirable number of general hospital beds?"

Nation-wide ratios cannot allow for local conditions

NEED FOR HOSPITAL care indicates the volume of service which should be provided ideally, while *demand* is the amount actually sought and used. Bed estimates, therefore, should be addressed to reality, reflecting potential usage within approximately a decade.

DR. BOURKE

Rarely will usage in two communities of similar identical populations be the same because it is unlikely that both will have an identical combination of cultural characteristics, age distribution, economic level, climate, industry, morbidity rate, quality of preventive and curative medical care, effectiveness of outpatient and home nursing care programs, and distributions of ancillary social welfare services.

Population ratios, addressed to an average goal and applied generically, can neither take full cognizance of such local variables nor indicate the demand for care in a given community. On the one hand, why build more beds than an area and its physicians are educated to use for years to come? On the other hand, why short-change an above-average, highly developed, economically healthy area educated to the proper, ideal and optimum use of hospital facilities? Although the deathbed-ratio formula, reflecting actual hospital usage in an area in relation to resident deaths, offers a more realistic approach, it is far from ideal today.

Fortunately, a more comprehensive approach to the care of the sick is emerging, making it essential that we think in terms of the *total* hospital demands of an area, of breaking down the barriers between and developing working relationships among the four categories of hospitals—general, chronic, tuberculosis and mental.

As a beginning, the so-called general and chronic hospital programs, facilities, services and staffs—and bed estimates—should be merged. Many "general" hospitals now have a high proportion of patients who, on the basis of diagnoses, are suffering from chronic diseases. Unfortunately, however, hospitals too often consider as chronically ill only the "long-term" patient, disregarding the fact that many "short-term" patients have an illness of longterm" impact upon the individual.

It is essential, therefore, that a competent, respected organization in the hospital field assume responsibility and leadership immediately for developing a realistic, practical method of estimating the over-all hospital bed requirements for a community, consistent with current philosophies and practices of hospital and medical care.—JOHN J. BOURKE, M.D., *executive director, New York State Joint Hospital Survey and Planning Commission, Albany.*

More study is necessary before decision can be made

THE RATIOS FOR general hospital beds per 1,000 population as written into the Hill-Burton Act are statutory ceilings, set up to facilitate a reasonable distribution of limited federal assistance among all categories of facilities. They are not necessarily absolute limits of total need.

DR. CRONIN

For planning purposes, the surgeon general and the Federal Hospital Council established regulations which fixed the statutory ratios as a minimum limit of adequacy. This was necessary in order to develop an equitable system of priority for projects, based on comparative unmet need. Developments in medical and hospital practice in the last five years have brought new or changing conditions affecting the need for and the use of hospital facilities, but I do not believe that there is sufficient clear evidence as yet warranting change in either the present statutory ceiling or the administrative floor, for planning total bed capacity in the states.

Several factors tend to result in a shorter stay per patient—early ambulation, new medicinals, earlier treatment. On the other hand, more people and physicians are using hospitals. The hospital is rapidly becoming the mobilization depot of the "tools" needed in the practice of medicine. Hospitals also are being used more and more by the physician as centers for diagnosis, treatment and prevention. There is now a wider popular understanding of health practices, an increasing economic ability to purchase care in many areas and a mounting volume of prepayment coverage by both commercial and cooperative insurance systems.

It must be remembered that effective demand is an entirely different matter than absolute need. Recent Blue Cross data for metropolitan New York, where coverage now amounts to 45 per cent of the population, shows a

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decrease in the average length of stay of members from 10.4 days to 9.1 days in the decade 1940-50, while the current national average is 8.1 days, in acute general hospitals. There has been no significant change in annual days of care per member in the New York area. Studies of this type are needed for other areas of the country.

I believe that in the last analysis, the determination of total need should be based upon the sum of many local community studies, in a related statewide pattern. The problem is not only medical, but socio-economic. Climate and poverty may be found to affect morbidity beyond what is presently identified. The considerable proportion of longterm care now provided in general hospitals has not yet been clearly appraised. There is no pat answer today, but self-examination by communities can give us many different valid and specific answers for local situations.

In summation, I think that further studies by many groups are needed to elicit facts showing whether or not the bed ratios now applied in the Hill-Burton program are still realistic. In the Public Health Service we are now examining hospital inventories contained in the official state hospital plans for evidence on the matter.—JOHN W. CRONIN, M.D., *chief, Division of Hospital Facilities, Public Health Service, Washington, D. C.*

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Recommended ratio is unrealistically high

HOSPITAL USAGE IN the state of Washington indicates that the recommended ratio of 4.5 general hospital beds per 1,000 population is unrealistically high. In the Northwest, a goal of 4.0 general beds per 1,000 residents would seem sufficient as a statewide average in view of the present expressed need or "demand" for general hospital facilities. This does not include beds for long term "chronic" patients or psychiatric cases which are logically cared for in units in conjunction with general hospitals.

MR. NIELSEN

There are now 3.6 acute general hospital beds per 1,000 population in use in the state of Washington, and few if any people are being denied accommodations. Under these circumstances, it would seem unrealistic to build an additional 2,000 beds at this time, as would be needed to fulfill the 4.5 ratio. At present, hospitals in some parts of the state are overcrowded, but in other parts of the state, hospitals have low occupancies.

The number of hospital beds which should be made available in Washington may best be estimated from present usage in each area of the state, modified by judgment of relevant factors and projected in accordance with anticipated growth and development. The factors affecting need include the availability of medical personnel; prevalence of prepayment, insurance and welfare plans; economic and educational status of the people; age composition of population; occupational patterns and industrial hazards, and climatic conditions. Only when research has

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analyzed usage into its various components, and further study has been given to factors affecting usage, will we be in a position to plan realistically for building and expanding hospitals.

A nationwide fixed ratio is, at best, a compromise of diverse needs in various parts of the United States. While a ratio of 4.5 per 1,000 is at present too high for this part of the country, the solution is probably not so much in lowering the base for calculation as in substituting criteria for estimation adaptable to the varying circumstances.—RALPH L. NIELSEN, *head, Hospital Planning and Development Section, Hospital and Nursing Home Program, Department of Health, State of Washington, Seattle.*

Present ratios are behind modern hospital planning

CONSIDERING our experience in California since the Hill-Burton Act became law, and in reviewing the work of the Commission on Hospital Care, I have come to the conclusion that our ratios are far behind modern hospital planning. In fact, most of these ratios are probably based on conditions that existed 20 to 25 years ago. It is evident therefore, that we need to consider an entirely new approach in order to develop a formula that could be used in any particular area.

MR. HEERMAN

In California, we have found that the formulas now in use are not realistic. The theoretical allotment of beds has proved, in general practice, not to be the real need. Many hospitals have been built which are now 40 per cent occupied and have become questionable as to solvency. Other areas, where statistics show that additional beds should be supplied, actually do not have any shortage of beds that can be proved by the percentage of occupancy of existing institutions in the area.

The Commission on Hospital Care tried to develop a certain formula based on the number of deaths and births in an area. In this proposal, for instance, the commission determined that 11 days of hospitalization were needed for each obstetrical patient. For the past five years, with the introduction of early ambulation, practically no hospital in California hospitalizes obstetrical patients for more than five days. Early ambulation certainly is here to stay.

Considering present costs of constructing acute units, it is also evident that every hospital should have a convalescent or recovery unit. Probably, in the not too distant future, the acute unit may hospitalize patients for only three to four days, and then the recovery or convalescent unit will have them for the balance of their stay. This is an important factor as the acute unit will cost upwards from $20,000 per bed, while the recovery or convalescent unit would cost less than $5,000 per bed.

I do not have a formula for determining the number of beds

(Continued on page 222)

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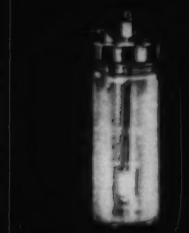

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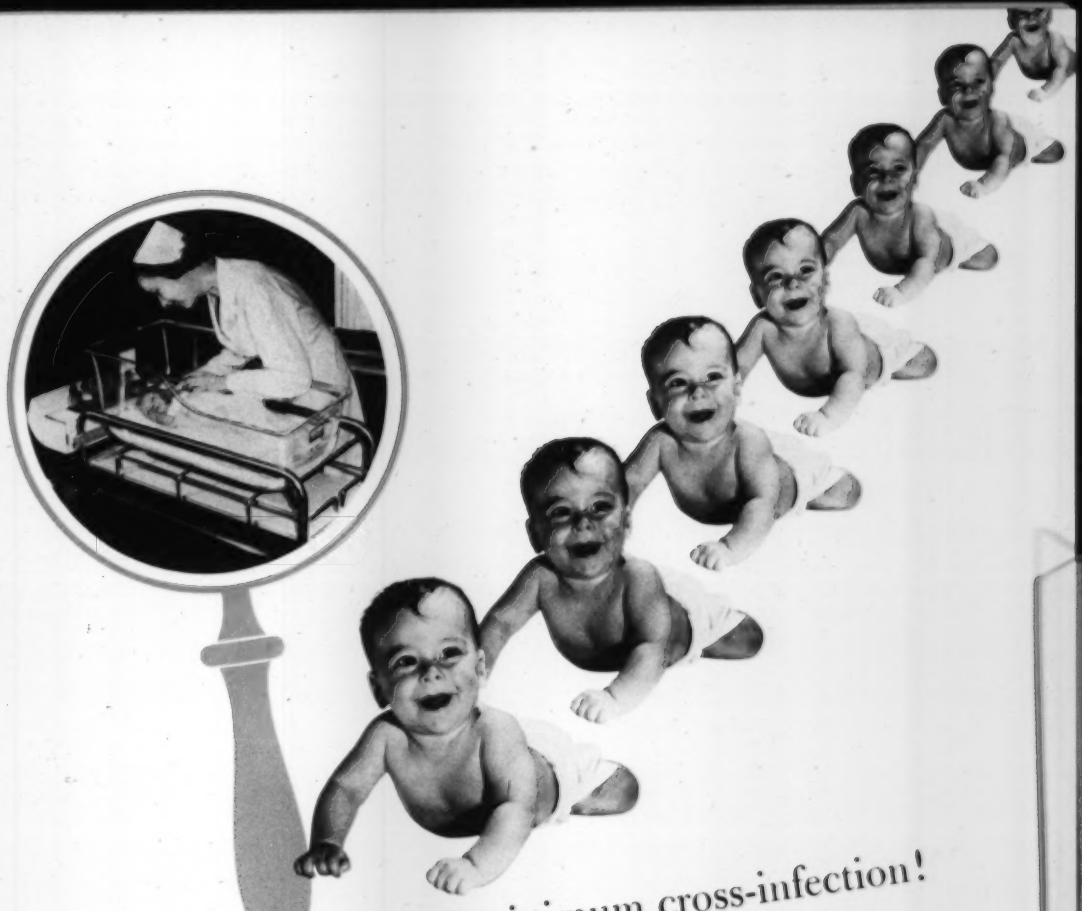

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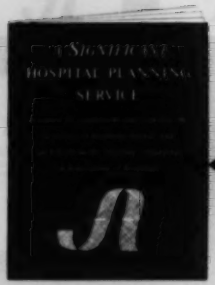

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the *Trend* is to SIZED ICE.. Tube-Ice

And Here's Why...

1 Only 3.6 KWH is required to make 100 pounds of Tube-Ice with the Vogt 2,000 Pound Package Unit . . . a figure unmatched by any other sized ice machine in the market.

2 Crystal clear Tube-Ice is made automatically, untouched by hands, and eliminates the LABOR, the WASTE, and the MESS of previous ice making systems.

3 Tube-Ice conforms to State laws and local ordinances covering the sanitary production and sizing of ice used for food refrigeration and beverage cooling.

4 The 2,000 Pound Tube-Ice Unit provides that needed ***extra capacity*** to meet peak loads in hotels, restaurants and institutions which use up to 1,000 pounds of sized ice daily.

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HENRY VOGT MACHINE CO., Louisville 10, Ky.

Branch Offices: NEW YORK, CHICAGO, CLEVELAND, DALLAS, PHILADELPHIA, ST. LOUIS, CHARLESTON, W. VA.

Vogt *Automatic* TUBE-ICE MACHINE

2,000 Pound Package Unit

At the flick of a switch

CRUSHED ICE or CYLINDER ICE

The *Finest* ICE MAKING UNIT EVER MADE

How Do You Hold Your Personnel?

Other vocations are actively bidding for *your* personnel.

And prospects of "better working conditions" may appeal to personnel who must work in areas *where offensive, upsetting odors are present.*

More than 1000 leading hospitals across the country have licked the odor problem by installing Airkem, the high quality, efficient odor counteractant. Their staffs are relieved of bothersome odors, thanks to Airkem's pleasing, air-freshened effect.

Airkem will kill offensive odors as they occur—before they have a chance to spread, because Airkem can be on duty constantly. Your hospital can be odor-protected at all times.

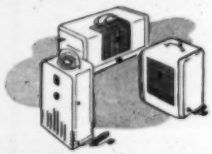
Airkem costs you less than the substitutes and imitators because less Airkem *by weight* is needed to do an efficient job. And Airkem lasts longer than cheaper, more volatile formulations.

Airkem combines Chlorophyll with more than 125 compounds found in nature to bring you an odor counteractant of unusual efficiency. It is compounded under strict laboratory control to assure utmost uniformity and maximum effectiveness.

Your Airkem supplier will be glad to help you obtain the most economical and most efficient odor protection for your hospital. Call him today or write to Airkem, Inc., 241 East 44th Street, New York 17, N. Y.

Airkem Mist dispenser for sudden or "emergency" odors.

Airkem Wick Bottles service approximately 100 sq. ft. Tamperproof wall cabinets available for permanent locations.



Airkem Osmefan H-2 treats approximately 300 sq. ft. . . . Airkem Osmefan V-4—approximately 600 sq. ft. . . . Airkem Osmefan H-8—approximately 1,000 sq. ft.

Airkem Wikfloat may be attached to "packaged" air conditioners to service intermediate spaces. Osmetrol, AE, for large central systems.

Odor-protect in all 9 trouble areas:

1 OPERATING ROOMS
2 AUTOPSY ROOMS
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5 LAVATORIES
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7 KITCHENS
8 LAUNDRY AND CHUTES
9 ODOROUS DISEASES

airkem THE ODOR COUNTERACTANT FOR PROFESSIONAL USE

Chef-of-the-month Domenic Schiarizzi says:

"You're Sure of Excellent Cooking with WEAR-EVER ALUMINUM"

You'll find Wear-Ever Aluminum Utensils assure perfect cooking *every time*. That's because aluminum spreads heat quickly and evenly and gives perfect fidelity to recipes. Foods always cook uniformly. And "friendly-to-foods" aluminum safeguards natural tastes and flavors.

Wear-Ever utensils are made of an extra-hard, extra-tough aluminum alloy. This unusually strong alloy withstands denting and gouging—gives extra years of service—cuts replacement costs. And Wear-Ever equipment stays new-looking—remains an asset to your kitchen. Remember, *only* Wear-Ever uses extra-hard aluminum alloy for *all* utensils. See your supply house representative or mail coupon below for details.

Chef-of-the-month—He's Domenic Schiarizzi, Executive Chef of the Sheraton Plaza in Boston, famous throughout New England for its wonderful cuisine. Chefs, dieticians and cooks everywhere prefer Wear-Ever Aluminum cooking utensils.

IN TWO STYLES

Any of the Wear-Ever Professional Stock Pot sizes listed below can be furnished with faucets and strainers at extra cost.

No. 4303....3 gals. No. 4307½..7½ gals.
No. 4305....5 gals. No. 4310....10 gals.
No. 4306....6 gals. No. 4315....15 gals.
No. 4320...20 gals.

Utensil-of-the-month—It's the new Wear-Ever Aluminum Professional Stock Pot. Stamped from an individual sheet of extra-hard, extra-tough aluminum alloy. Sides and bottoms are of uniform thickness. Utensil has new-type, sanitary open bead for easy cleaning. Available in seven sizes from 3 gallons to 20 gallons.

WEAR-EVER Aluminum

WEAR-EVER ALUMINUM TRADE MARK REG. U.S. PAT. OFF.

The Aluminum Cooking Utensil Company
3304 Wear-Ever Bldg., New Kensington, Pa.

Please send me your catalog of Wear-Ever Utensils for restaurant, school, club and hospital kitchens.

NAME .....

TITLE .....

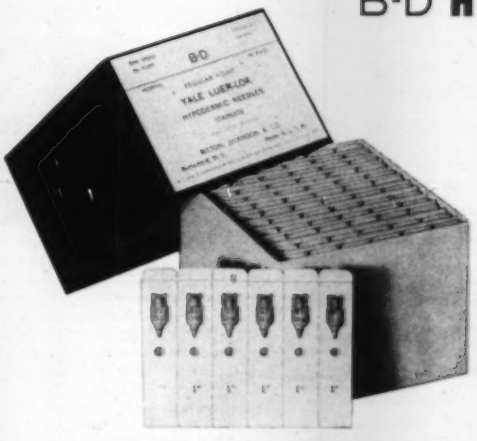
Fill in, clip to your letterhead and mail today

Would you PAY $1.00 for these EMPTY BOXES?

You wouldn't knowingly waste a single penny on an empty box for which you had no use, would you?

Yet when you use B-D Hypodermic Needles by the gross, and have to buy them by the dozen, you pay $1.00 for unnecessary packages every time you purchase twelve dozen. To eliminate this waste . . . to save money . . . B-D offers the

HOSPITAL PACKAGE of B-D HYPODERMIC NEEDLES



Specify Catalog No. H-LNR for Hospital Package.

Needles are affixed to perforated cards for protection and ease in dispensing individual needles. ½ dozen per card, 24 cards (144 needles) per package. The Hospital Package is available for the following eleven popular size needles:

No. H-LNR	LIST PRICE PER GROSS
26 gauge; ½ inch	$28.50
25 gauge; ½, ⅝ inch	28.50
24 gauge; ¾ inch	28.50
23 gauge; 1 inch	28.50
22 gauge; 1, 1½ inch	34.50
20 gauge; 1, 1½ inch	34.50
19 gauge; 1½ inch	37.50
18 gauge; 1½ inch	37.50

You can also save at least $12.00 per gross on B-D YALE and B-D DYNAFIT Syringes by purchasing the Hospital Package of 3 dozen of a single size and type.

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B-D, Trademark Reg. U.S. Pat. Off.

CONTOUR—

the modern hospital sheet—is preferred by...

DOCTORS

... because Contour Sheets help patients to rest more comfortably during the day, sleep sounder at night. The use of these sheets disturbs bedridden or seriously ill patients less during bedmaking. Mitered corners slip easily over the mattress ... the tuck-under falls into place automatically, pulls the sheet taut.

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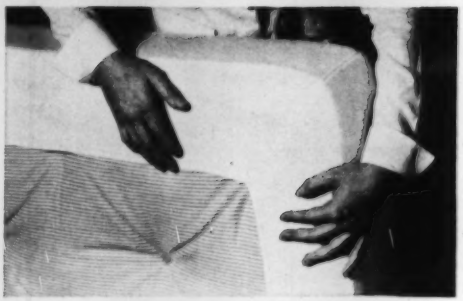
... because Contour Sheets save bedmaking time, free nurses for more important duties. The Contour Sheet* is easy to put on ... requires no bending, stretching or heavy lifting. Since Contours don't wrinkle and can't pull out, they eliminate retucking, stay fresh longer without changing. Mattress pads stay flat when back and knee rests are raised and lowered.

HOSPITAL MANAGEMENT

... because Contour Sheets lower replacement costs. Since they need less frequent changing, they get less wear-and-tear in the laundry. And because they weigh less than conventional sheets, they cut laundry costs. Ironing is optional. Contours come in four standard hospital sizes, Sanforized* for permanent fit. Write to Pacific Mills, 1407 Broadway, New York 18.

*Reg. U.S. Pat. Off.



Pacific Mills offers sincerest congratulations to the Pacific Mills Hospital Educational Fund Scholarship Winners for 1952 for the Hospital Housekeeping Course, sponsored by the American Hospital Association at Michigan State College.

Mr. Roscoe C. Adams, Jr.
Massachusetts Eye & Ear Infirmary
Boston, Massachusetts

Mrs. E. L. Garritt
Halifax Hospital
Daytona Beach, Florida

Mrs. E. K. Johnson
Butterworth Hospital
Grand Rapids, Michigan

Mrs. H. K. Johnson
Menninger Foundation
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Cleveland, Ohio

Mrs. R. K. Pearson
U. of Oklahoma
School of Medicine
Norman, Oklahoma

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Kansas City, Missouri

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Imola, California

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PACIFIC MILLS... WEAVERS OF FINE COTTONS, RAYONS, WOOLENS, WORSTEDS

IN INFECTED WOUNDS AND CHRONIC LESIONS

INDICATIONS

General Surgical Use

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Subcutaneous Hematomas
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Decubitus Ulcers
Soft Tissue Abscesses, Sinuses, Fistulae
Infected Compound Fractures
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SUPPLIED: Tryptar is supplied as a two-vial preparation: one 30 cc. vial containing 250,000 Armour Units (250 mg. of tryptic activity) of highly purified crystalline trypsin; the companion 30 cc. vial containing 25 cc. of Tryptar Diluent (Sorensen's Phosphate Buffer Solution) pH 7.1; plus plastic adapter for use with powder blower. Write for literature on methods of application.

In chronic lesions and infected wounds, Tryptar greatly facilitates healing by removing obstacles which interfere with the natural defense mechanisms of the body. Tryptar rapidly dissolves necrotic tissue, pus and pyogenic membranes by selective proteolytic digestion, without injury to living tissue. Control of topical infection is attained.

Effective and speedy non-surgical debridement is accomplished by an entirely physiologic agent devoid of antigenic and sensitizing properties.[1]

Tryptar affords remarkable savings in medical care . . . dramatically reduces recovery time . . . shortens length of disability. Applied as powder or wet dressings.

1. Reiser, H. G., et al.: Arch. Surg. 63:568-575, 1951.

Tryptar

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PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

An extra hand FOR BUSY NURSES!

Along with Auto-Lok's tremendously important features of controlled ventilation and positive tight closure, the added convenience of "one-hand" operation is a great boon in busy hospitals. With a tray in one hand, any nurse can open, close or adjust Auto-Lok Windows in a matter of seconds...and, *effortlessly*, too!

No more running to close windows...

No more stuffy, humid rooms when it rains. The rain can't come in through Auto-Lok's slanting vents! In cold weather they keep the heat in and the cold out...save enough in heating costs to pay for themselves over and over again. In warm weather they open widest to catch every breeze, but no drafts...or, close tight to conserve air conditioning.

Minimum of maintenance...

Because Auto-Lok Hardware, perfectly balanced and designed for a lifetime of effortless, "no-wear" operation, *will never require adjustment!* Easiest window in the world to clean...because all glass can be cleaned from the inside!

Auto-lok
ALUMINUM WINDOWS
For Your Hospital

Tightest closing window ever made!
Seals itself shut like the door of a refrigerator!

Special nite vent!
Can remain slightly open to admit fresh air, while upper vents are closed and locked.

MORE THAN A DOZEN *OTHER* FEATURES YOU WILL WANT TO KNOW...write for complete information regarding AUTO-LOK Windows for your hospital!

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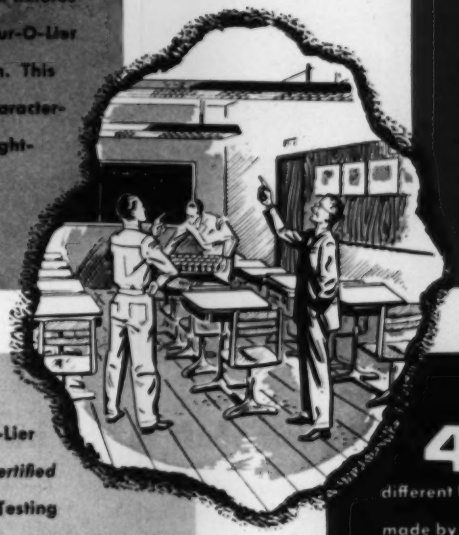
Box 4541, Dept. H4, Miami, Florida

LUDMAN LEADS THE WORLD IN WINDOW ENGINEERING

YOU GET 4 EXCLUSIVE ADVANTAGES WHEN YOU SPECIFY

FLEUR·O·LIER

1 Only Fleur-O-Lier fixtures are rated on the Fleur-O-Lier Index Rating System. This gives illuminating characteristics, shielding, brightness, etc., for each fixture.



2 Complete photometric test data including distribution curves and coefficients of utilization tables are computed by Electrical Testing Laboratories, Inc., and are provided for every Fleur-O-Lier luminaire.

3 Fleur-O-Lier fixtures are *certified* by Electrical Testing Laboratories, Inc., as complying with rigid specifications covering electrical and mechanical construction.

4 More than 300 different Fleur-O-Lier fixtures made by nearly 30 manufacturers give you a wide selection from which to choose.

THESE 4 ADVANTAGES ASSURE *Lighting Satisfaction* WHEN YOU SPECIFY FLEUR-O-LIER

Free Booklet

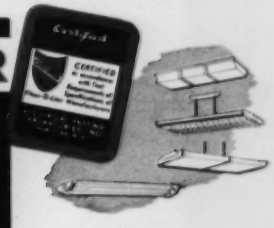
Write for your free copy of the new booklet giving complete details of the Fleur-O-Lier Index System.

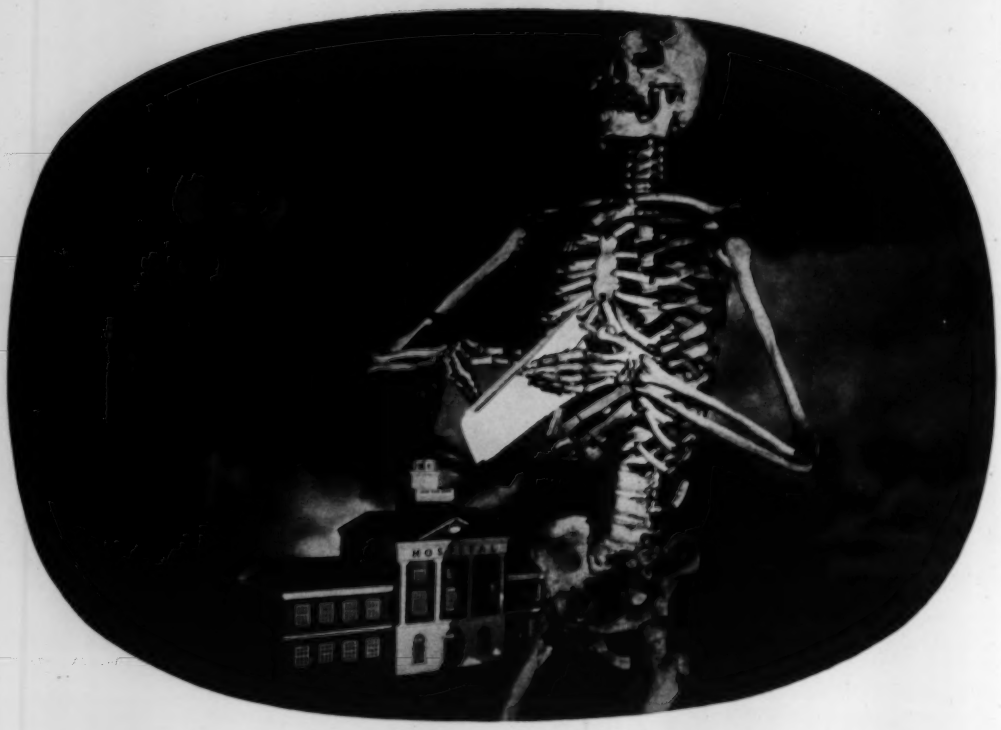
FLEUR·O·LIER

Manufacturers

2116 Keith Building • Cleveland 15, Ohio

Fleur-O-Lier is not the name of an individual manufacturer but of a group of fixtures made by leading manufacturers. Participation in the Fleur-O-Lier program is open to any manufacturer who complies with Fleur-O-Lier requirements.





Have they cut your staff to the bone?

When a budget slice says something's got to give, it's usually your administrative staff that takes the skinning.

You *can* administrate a hospital with a skeleton staff—*if* you have a record-keeping system that means business.

Take McBee Keysort cards and machines for instance. They lighten work loads by increasing clerical efficiency and accuracy. Listing a patient's background, itemizing costs and recording information of all kinds becomes easy with Keysort Charge Tickets.

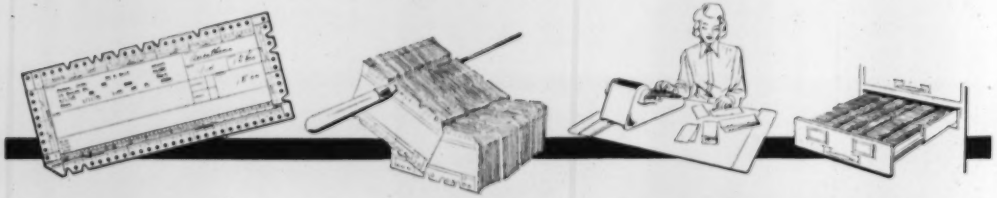
With existing personnel, *without* costly installations or major procedural changes, Keysort Charge Tickets provide complete cost-control information at less cost than any other method.

When notched, the pre-coded holes along the edges of each Keysort Charge Ticket make it easy to *collect* the facts on each patient . . . *classify* them . . . *file* them . . . *find* them . . . *use* them . . . quickly and accurately.

For analyzing expenses and income by contractual classifications, Keysort Charge Tickets, together with McBee Unit Analysis, furnish reports of current and cumulative figures.

Other McBee methods put your payroll, patients' ledger and inventory on a businesslike basis.

The McBee representative near you is trained to analyze your record-keeping problems and remedy them. Call him. Or write us.



THE McBEE COMPANY

Sole Manufacturer of Keysort — The Marginally Punched Card
296 Madison Avenue, New York 17, N. Y. *Offices in principal cities.*

How Fires Start . . .

Carelessness

According to statistics, fire strikes an average of 3 hospitals daily. Moreover, the belief that lightning never strikes twice in the same place is consistently disproved.

Fires are habitual repeaters, starting again and again in the same kinds of places . . . kitchens, basements, laundry chutes, storerooms and closets. And, from the same causes . . . which turn out to be just plain human carelessness, in most cases. For example, the ordinary guy who unthinkingly tosses away a lighted match.

How Fires Are Stopped . . .

Grinnell Sprinklers

Education does a world of good to prevent fires from starting. But until human behavior is perfect, your best protection lies in automatic control.

The surest control is with Grinnell Automatic Sprinkler Systems, which check fire at its source, wherever and whenever it may strike, with positive certainty.

In hospitals, there is a moral obligation upon management for the utmost protection of life and property. So, for your own sake, be sure the lives for which you are responsible are protected with Grinnell sprinklers, your assurance of automatic fire protection.

GRINNELL FIRE PROTECTION SYSTEMS

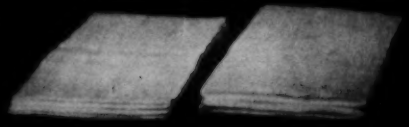
MANUFACTURING • ENGINEERING • INSTALLATION • SINCE 1870

GRINNELL COMPANY, INC., PROVIDENCE 1, RHODE ISLAND • BRANCH OFFICES IN PRINCIPAL CITIES

..."and we're saving hundreds of dollars every year by using ZOBEC and RAY-TEC sponges"

Four 4" x 4"—16-ply all-gauze sponges

Two Zobec 8" x 4" sponges



TWO Zobec sponges 8" x 4" are equal in bulk and absorptive capacity to FOUR all-gauze sponges 4" x 4"—16 ply. At the time of going to press the best published prices are—

4000 all-gauze sponges 4" x 4"—16-ply—cost **$59.48**

2000 Zobec sponges 8" x 4"—cost **$33.16**

Zobec Sponges save 44⅘% or **$26.32**

In all other sizes Zobec sponges are correspondingly lower in cost than all-gauze sponges.

Smaller sizes of Zobec cotton-filmated Sponges

ZOBEC + + + +

(cotton-filmated) SPONGES

—for post-operative dressings. Extra bulk and soft fluffy texture provide greater capacity—greater dressing volume. Tremendous savings are possible by adopting heavy duty 8" x 4" size when multiple dressings are required. Further savings are possible by adopting smaller sizes (3" x 3" or 2" x 2" as illustrated) for single sponge applications.

Standardize on ZOBEC and RAY-TEC —get all these advantages of economy and improved procedure

By changing from all-gauze sponges to Zobec (cotton-filmated) sponges for post-operative dressings, and to Ray-Tec (X-ray detectable) sponges for surgery, you can cut sponge costs between 6% and 10%... yet assure an improvement in dressing technique.

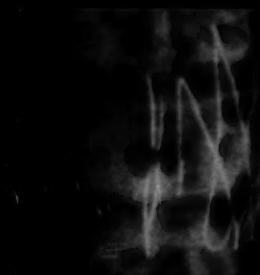
Ask your J&J representative to figure the savings on your requirements.

+ + + + +

(X-ray detectable) SPONGES

—for operating room use. Protection for the hospital, surgeons and nursing staff. X-rayable insert with barium sulfate U.S.P. eliminates uncertainties when sponges are "lost". Have many advantages:

- *soft, non-abrasive*
- *cover wide area on X-ray film*
- *easily detected, even behind bony structures*
- *instantly identified by long black monofilament*
- *provide distinctive pattern (as illustrated).*



AN UNMISTAKABLE PATTERN—*The Ray-Tec "string pattern" covers a wide area and cannot be confused with body structures or artifacts.*

HOSPITAL DIVISION

NEW BRUNSWICK, N. J. CHICAGO, ILL.

Architect: FUGARD, BURT, WILKINSON & ORTH, Chicago, Ill.

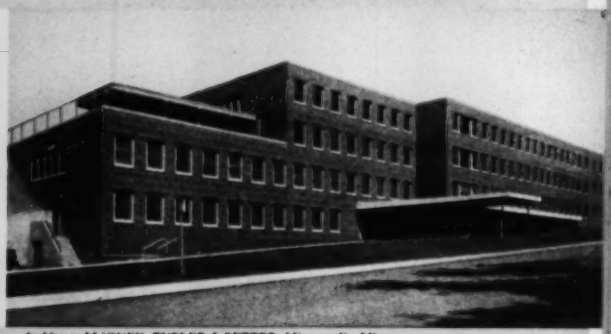
The August, 1951, selection as Modern Hospital of the Month was Memorial Hospital, St. Joseph-Benton Harbor, Michigan

Architect: STANTON & HILLIER, Detroit, Mich.

Oakwood Hospital, Dearborn, Michigan was the September, 1951, choice for Modern Hospital of the Month

Architect: SCHMIDT, GARDEN & ERIKSON, Chicago, Ill.

October, 1951—St. Luke's Hospital, Saginaw, Michigan



Architect: MAGNEY, TUSLER & SETTER, Minneapolis, Minn.

November, 1951—Variety Club Heart Hospital of the University of Minnesota Hospitals, Minneapolis, Minn.

Architect: ISADORE ROSENFIELD, New York, N.Y.

December, 1951—North Shore Hospital, Manhasset, L. I., New York. (Equipment specified "NCG or equal".)

Architect: JOHN W. MALONEY, Seattle, Wash.

January, 1952—St. Joseph Hospital, Aberdeen, Wash.

Six consecutive "*Modern Hospitals of the Month*" choose **NCG** oxygen piping equipment...

The hospitals above are those chosen for six consecutive months as "The Modern Hospital of the Month" by Modern Hospital magazine. All six of these hospitals have chosen NCG equipment for their oxygen piping systems.

Such unanimity of preference is no coincidence. An ever increasing number of leading hospitals, architects and builders regard NCG as the outstanding source for oxygen piping equipment. They like the completeness of the NCG line . . . its excellent design and construction . . . and the helpful assistance offered by NCG in the planning and installation of oxygen piping systems.

NCG's experienced counsel on oxygen piping installations for hospitals now in operation and new buildings in the blue-print stage, is available to you without cost or obligation. Your inquiry will receive prompt attention.

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MEDICAL DIVISION

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Fenestra Windows in G.M.S. Veterans Hospital, Omaha, Nebraska
Architect: Ellerbe & Co., & Leo A. Daly Co.
Contractor: Peter Kiewit Sons' Co. & Associates

Give Your Patients More Daylight and Controlled Fresh Air with *Fenestra* Intermediate Steel Windows!

Some of the best medicine is free—like lots of bright cheerful daylight . . . a peaceful, restful view of the sky . . . the clean, sweet breath of the outdoors. So open up your rooms with Fenestra* Intermediate Steel Windows.

Why *Fenestra?* Because the frames of standardized Fenestra Intermediate Steel Windows are cleverly designed to be strong and rigid *without* being bulky! That permits *more glass* per window . . . more *light* . . . more *view.*

And a nurse can control ventilation—with one hand. The easy-opening vents protect against drafts and give controlled ventilation . . . in any kind of weather. These wonderful windows are washed and screened from *inside.* And their graceful lines give the hospital architectural distinction—inside and out.

Compare Fenestra's triple savings: *Low first cost* . . . volume production. *Low installation cost* . . . modular sizes. *Low maintenance cost* . . . steel *lasts.* Choose standardized Fenestra Intermediate Steel Windows . . . engineered to cut the waste out of building.

Fenestra Galvanizing Slashes Window Maintenance Costs

No more painting! Fenestra's Super Hot-Dip Galvanizing completely protects Fenestra Windows. It's done in Fenestra's own new plant with special tanks, special automatic controls, where everything is geared to give you the most *permanent* windows made. It is the only plant in America especially designed to galvanize steel windows. These windows are available on special order.

For further information, call the Fenestra Representative or write to Detroit Steel Products Company, Dept. H-4, 2214 East Grand Boulevard, Detroit 11, Michigan. •③

Send for your free book on how Fenestra Super Hot-Dip Galvanizing makes Fenestra Steel Windows stay new.

Windows that make the most of Daylight and Fresh Air *Fenestra*

Logically

. . . You'll want to eliminate outmoded technics and equipment with

POUR-O-VAC SEALS

the modern, reusable hermetic closure for sealing, storing, handling and conserving surgical fluids.

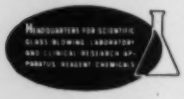
THESE FACTS ARE CONVINCING . . .

Pour-o-vac Seals eliminate the possibility of sterile water contamination caused by intake of bacteria-laden dust . . . avoids contamination by unfiltered air.

They serve a secondary function of providing a dustproof seal for remaining fluid when only the partial contents of a container are used. Of importance, they are interchangeable with all Fenwal 3000, 2000, 1000 and 500 ml. containers.

In permitting contents to be stored for long periods under vacuum . . . periodic testing for sterility without breaking the hermetic seal . . . pouring of contents from a non-drip sterile lip, Pour-o-vac seals eliminate the wasteful, time-consuming and questionably scientific method of sealing with gauze, cotton, paper, string and tape.

ALSO INVESTIGATE—Fenwal Automatic Washing Units, capable of accommodating and thoroughly cleansing 4 containers in 30 seconds.



ORDER TODAY or write immediately for further information

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MACALASTER BICKNELL COMPANY

243 Broadway **Cambridge, Massachusetts**

Four-Point Study on Financing Hospital Care

HARRY BECKER

The Commission on Financing of Hospital Care, after several months of planning is now ready to enter the fact-finding phase of its two year program. This article is a progress report on how the Commission defined its areas of greatest interest.

WHEN THE Commission on Financing of Hospital Care had its first meeting in Washington late in November 1951, the question of major concern to the commission members—and, for that matter, to all persons interested in hospitals—was "how do we 'get hold' of the problems associated with the financing of hospital care for the American people?"

Today the commission is close to its goal of "getting hold" of the problems to which it will direct its attention. The commission's technical advisory committee* had its first meeting late last month. It reviewed the more than 300 problems relating to hospital financing which were proposed by persons participating in the five regional conferences sponsored recently by the commission. It also reviewed problems suggested at a number of special conferences with professional, consumer and other representatives.

Using these suggested problems as reference, the technical advisory committee has outlined the study projects which it believes are a prerequisite to a better understanding of the problems of financing hospital care. Late this month the entire commission will review the advisory committee recommendations and adopt the specific projects which it will undertake as part of its national study program. Then the national study, as distinguished from the state study already in progress in North Carolina, will move out of the planning and into the fact-finding phase.

The regional and other conferences which the commission directed its staff to conduct are indicative of the care and objectivity taken in isolating the problems before planning specific projects. It probably is true that no other research previously undertaken in the health field has sought the advice and cooperation of so many individuals not personally indentified with the study prior to the time the particular study projects were formulated.

The study objectives prepared by the initial planning group will guide commission policies during the expected two-year span of the study. The scope of these objectives, however, was made—deliberately—broad enough to cover all facets of a very large problem and therefore was too broad to be encompassed adequately in two years with a budget of only $500,000. So the commission has the task of setting its own outward limits. This was the reason for the effort to learn the problems of general concern. Members of the commission decided that the conference technique would help them set their priorities.

Another reason for the conferences was the commission's interest in stimulating active participation in its program. This participation implied more than just assistance in fact finding; it included sharing in the conception and planning of its program. The commission wanted to avoid the "brain-truster" technique of setting up a program without first knowing what the interested groups needed. When hospital economics is discussed, it believes the hospital administrator, along with representatives of the many other groups concerned (including the consumer), should be sitting at the conference table.

The commission also wants to

Mr. Becker is associate director of the Commission on Financing Hospital Care which has its offices in Chicago.

*See News.

stimulate an exchange of ideas and experience between all groups, both professional and public, concerned with the problem of hospital financing. It is expected that an important function of the commission will be this exchange of information and experience and its subsequent evaluation by the group. Thus, cooperative relationships will be established between the people who pay for hospital care and the professional people who provide the care and services. The commission asked five persons in as many cities to sponsor a meeting of people "with a wide range of interests and points of view." Cooperation was prompt and energetic. Persons from about half the states in the country, representing hospital administration, medicine, "third-party" agencies, public health, welfare, education and the public or the consumer were invited to participate in one-day conferences held in the West, the East, the South, the Southwest and the North.

REPRESENTATION

The number of participants at each meeting was initially scheduled "not to exceed 18 or 20," but 35 or 40 were sitting around the table when the conference opened. And the "interested" group around the table included as many bankers, editors, public officials, university presidents, labor leaders, business men and representatives of rural people as hospital administrators, physicians and technical people.

There frequently was prolonged discussion among the conferees in determining fine shades in meaning and implication of questions. Considerable effort was applied to the task of providing inclusive, technically-sound questions.

One question suggested another. At the end of the day, 50, 60 or, as at one conference, 72 questions were listed on the blackboards. When these regional conferences were concluded the commission was confronted with 315 questions and a tremendous job.

The conference questions covered as wide a range of problems as those conceived by the American Hospital Association's planning committee when the commission's seven original objectives were formulated. They helped, however, to translate the objectives into practical day-to-day operating problems and gave the commission a useful index of the need for particular types of studies.

The conference provided another index of this need. At the end of the day participants of each conference were asked to summarize their questions into a priority list of five to seven questions or problem areas. A few minutes more were allowed for review of the day's questions before the final summary of problems was listed on the blackboard. Although the method of expression varied at each conference, the underlying "worries" or "concerns" presented a striking similarity. Likewise, the weight given various problems did not differ very significantly between regions.

Generally, there seemed to be a widespread belief that the cost of providing hospital services would continue to rise in the foreseeable future. The conferences reflected an attitude expressed recently by an administrator of a large teaching hospital to the effect that "You don't meet the problem of financing hospital care by substituting 25 watt bulbs for all your 50 watt bulbs." There was, however, concern about methods of reducing costs of particular services through more efficient and effective methods of hospital operation.

The major concern was in finding means to *expand* hospital services while keeping costs within reach of the buying public. The majority of the questions dealt with the "extrinsic" problems of hospital financing involving methods and means of payment as distinguished from the "intrinsic" problems pertaining to the management factor. Problems associated with prepayment received more stress than any other extrinsic problem.

FOUR POINTS

A preliminary analysis of the 315 regional conference questions prepared by the staff placed the questions into four major groups:

1. *Current economic status of hospitals today and an evaluation of factors which appear to affect cost of hospital care from a long range point of view.* More than one-third of the questions are classified under this heading. There was concern over how and to what extent the factors which are increasing costs can be controlled. Special attention was given to the fact that: standards of care are improving and will continue to improve; the supply of beds and the number of physicians will increase as consumer demand grows; an aging population will increase demand for hospital care; and the high level of national economic activity, with its associated problems of labor supply and labor costs, must be a major consideration in hospital economic planning.

2. *How are we going to finance hospital care for non-wage and low income groups?* At all regional conferences the final summary of questions recommended to the commission for study included the problem of how to finance hospital care for the public assistance and public aid categories, persons receiving unemployment compensation, the aged and retired, the migratory and seasonal workers, the unemployed, disabled, rural labor, service men's dependents, and widows and children living on social insurance benefits. Also included in this group were persons with prolonged and chronic illnesses. It was asked whether or not these groups should be brought into prepayment plans, and, if so, how. Requested also was a definition of governmental responsibility for these groups and of ways it should be exercised.

3. *What is and what should be the relationship of third-party payers (prepayment plans and government agencies) to the hospital, the physician and the public?* The large proportion of questions in this category and the fact that all regional conference summaries included some phase of this problem is evidence of the growing national importance of the "third party" agency. Questions in this group were posed as often by third-party representatives as by the hospital administrators, the medical profession, or the consumer representatives. Specific questions pertained to: methods for determ-

ining payments to the hospital; whether payments to the hospital for ill patients also should cover the costs of medical education and research, stand-by services and capitalization; utilization of varying patterns of organization of medical services and methods of paying physicians. Also stressed was whether or not development of outpatient and home care programs under payment will reduce use of in-hospital services. Another question frequently suggested was how hospital administrators and their staffs may be motivated to "hold down" costs when third-party agencies guarantee payment for a high percentage of hospital admissions. Underlying all these questions was the general question: "What is the future role of the third-party agency?"

4. *What is the role of the community in meeting the problems of hospital financing?* All conference groups proposed questions and all but one group suggested in its summary of questions that community planning as a tool for encouraging higher standards of care and maximum coordination and integration of community services should be given particular attention in the commission's study. The questions concerned analysis of the *process* of community planning as well as an evaluation of its effectiveness and role in relation to hospital financing.

At every conference, the questions stressed, in some way, the need for a public better informed on hospital costs. There was a general feeling among participants that a major function of the Commission on Financing of Hospital Care should be an extensive program of public education. Many said they felt that the problem of hospital financing would not be solved until means are found to stimulate a general public willingness to allocate consumer funds to prepaid hospital protection.

Most encouraging is the recruitment, at such an early stage in the program, of so many individuals representing such a wide range of skills and interests who have been willing to share their thinking with the commission. In the planning of the research projects is the thinking of individuals concerned with *all* aspects of the problem. The ideas of the original planning committee appointed by the American Hospital Association have been augmented and defined by the regional conferences and by the informal conferences held in many areas throughout the country.

With this direction the commission, with the aid of its technical advisory committees and its staff, will have the background information necessary to develop its two-year program in a manner that will accomplish its purpose—finding ways of adequately financing our hospitals which will bring the highest quality of hospital services within reach of all groups.

DR. EDWIN CROSBY

appointed director of accreditation

EDWIN L. CROSBY, M.D., president-elect of the American Hospital Association and director of The Johns Hopkins Hospital, Baltimore, has been selected as the fulltime director of the newly-organized Joint Commission on the Accreditation of Hospitals.

Dr. Crosby will assume his new duties on September 1, with headquarters in Chicago.

The commission, operated jointly by the American Hospital Association, the American Medical Association, the American College of Surgeons, the American College of Physicians and the Canadian Medical Association, will take over the hospital standardization activities carried on by the American College of Surgeons for the past 34 years.

In addition to being a physician and a hospital administrator, Dr. Crosby is a doctor of public health and a medical and public health statistician. He received his medical education at Albany Medical College and was awarded a degree of doctor of medicine in 1933. His master of public health and doctor of public health degrees were earned at Johns Hopkins University in 1936 and 1937.

His first hospital administration post was at Ellis Hospital, Schenectady, N. Y. After five years of public health work in New York state, he became first assistant director at the Johns Hopkins Hospital, and he became director in 1946.

Advice from an Administrator's Secretary

Organize your HOSPITAL FILES

DOROTHY OGLEY

IF ANY hospital administrator's secretary has developed a "Never-Fail Filing System," this is an urgent request that she immediately send us full particulars, air mail, special delivery, postage collect, and we shall, in return, give her our eternal gratitude.

While administrators cope with the manifold problems of budget, nursing shortage, rising costs and countless other questions, we secretaries have the ever-present worry, when it comes to communications on each of these countless subjects, of "Where shall I file it?" This query goes along with the dread moment when the boss says, "Will you please get out of the file for me . . .?" And while the subject and date may have been stated exactly and specifically by him, the request can be a challenge far from promptly met. Facing the row of file drawers, an inner voice starts dinging, "Where . . .? O, where . . .?"

Most secretaries must be familiar with those occasions symptomatically recognized by the sinking heart, the pounding pulse, the dry throat which accompany The Search, as minutes speed by and the boss and a busy assistant or department head (perhaps the entire administrative staff) wait and wait and *wait* for the appearance of the missing letter, the elusive directive, that memorandum which seems to be buried somewhere as deep as Davey Jones' locker.

We readily admit this happens to us now and then. We have, however, given a great deal of time and thought and study to our filing system, have brooded and pondered —and *reorganized*. Certainly no final answers bobbed up. But at least we have found a method that seems to be a vast improvement over our former hit-and-miss mode of filing, which included the impulse to thrust any communication that seemed to belong in no particular alphabetical place, into one capacious folder labeled "P" for Puzzled.

In reorganizing our files, we first separated all the inter-hospital communications from those coming from outside the hospital. For instance, our nursing files are in one section of the file drawers; in another section are public health letters from city, county, state and national bureaus.

In the files, large subject headings, such as nursing, are broken down this way:

NURSING SERVICE—GENERAL
NURSING SERVICE—DIRECTIVES
NURSING SERVICE—HEALTH
NURSING SERVICE—APPOINTMENTS and RESIGNATIONS

NURSING SCHOOL—GENERAL
NURSING SCHOOL—APPOINTMENTS and RESIGNATIONS
NURSING SCHOOL—REGISTRATION
NURSING SCHOOL—SCHOLARSHIPS

For further ease and speed, we use variously colored gummed labels and colored file folders. For example all nursing service labels are white, nursing school labels are blue, business office labels are yellow, and surgery labels are green. For the most frequently-used files, or ones which we usually need in a hurry, we use bright-colored file folders, such as red, green or blue. There is one important file in our office which is in a green folder—and it is the *only* green one. Whether it is on the boss's desk, on my desk or in the file drawer, it always can be found immediately.

In filing a communication which has to do with several different departments, we reduce the subject matter to "its lowest common denominator." For instance, if a memorandum on blood typing has been duplicated and sent to the house staff, nursing service, clinical

"Miss Jones, the Doe letter of Jan. 22."

"I'm sure I filed it under D . . ."

Mrs. Ogley is secretary to Anthony J. J. Rourke, M.D., physician superintendent of Stanford University hospitals, San Francisco, and president of the American Hospital Association.

laboratory and business office, we file the memorandum under Blood Typing. If a new agreement has been reached on the responsibility of the pediatric service and the surgical service in working up cases on children's ward, the communication is filed under Pediatrics, as that is the basic subject. If we want to keep a rather complete record of an anniversary party for employees who have been on the payroll for 25 years or more, it would be filed in the Personnel folder. If such material were filed alphabetically, where would it go—"A," "P," "Q"—or what have you?

This shows why we are partial to subject filing for most of our letters and other communications, though, of course, we do have alphabetized folders for both our hospital and "outside" communications which fall into the inevitable "miscellany" category.

We require three times as much space for our inter-office correspondence as for correspondence outside the hospital. To keep any of the files from getting overcrowded, however, we sort through each file folder sometime during the first quarter of each year, transferring as much as possible to the basement (yes, our basement is crowded, too!). During this procedure we use as a guide, the American Hospital Association's Manual of Hospital Records Administration.* We have found to be of particular value the discussion on Retention and Disposal of Records under Section V on page 35.

Here is an example of our "weeding." A last-year's memorandum to department heads, advising that the hot water would be turned off for one hour on the Fourth of July, has no current value and should go into the "round file" (wastepaper basket). A directive dated five years ago, regarding the stocking of certain drugs on specific hospital floors, however, is still current and vital as there has been no subsequent directive on this subject. Even though it is five years old, it should be retained in the current file.

We also try to keep our file drawers looking neat. There seems to be a psychological snag in rushing to a mussy drawer where letters have been thrust hastily into the folders and bulge every which way. We always make an effort to keep all the paper edges even, the folders clean and the labels neatly typed and pasted on the folder.

Filing hours are reserved for days when the boss is either out of his office or tied up for some time and does not want to be disturbed. This gives the secretary more chance to think about where she is going to file each communication, and later she more easily should remember *where* she has put it.

As the manual so clearly states, organizing a hospital administrator's file is a job that has to be "tailored to fit" individual requirements. And above all else, being custodian of those files is a job that requires *remembering*. For upon the administrator's secretary may depend more than just the ordinary business transactions.

"Oh, dear, Mr. Davis.—In just a minute."

"Now, let's see . . ."

"See, it was on my desk all the time. Here, Mr. Davis, I've had enough."

*Hospital Records Administration: Manual of Procedures, American Hospital Association, 1949.

Standardization

——— its impact on tomorrow

The story of how an idea grew and laid the foundations for the new Joint Commission on Accreditation of Hospitals.

MALCOLM T. MAC EACHERN, M.D.

After 34 years of successful and praiseworthy work in carrying on Hospital Standardization, the American College of Surgeons is withdrawing from the sole responsibility of this activity to become one of the participating organizations in the recently formed Joint Commission on Accreditation of Hospitals. Commission membership will come from powerful and influential organizations —the American Medical Association, the American Hospital Association, the American College of Surgeons, the American College of Physicians, and the Canadian Medical Association, with a total membership of 20. This Commission will administer and finance the Accreditation of Hospitals and conduct the work much on the same basis as the American College of Surgeons.

Shortly, the designation *Hospital Standardization*, almost a household and world-wide term, will disappear and henceforth the work will be known as the *Accreditation* of Hospitals. The far-reaching influence of the Joint Commission as set up will be felt even beyond the shores of the United States and Canada, helping to assure the patient the best possible care that scientific medicine can offer.

EVALUATION

An evaluation of Hospital Standardization over its 34 years of existence shows many benefits to the patient. The patient is assured efficient care through better medical staff organization, competent personnel, and adequate diagnostic and therapeutic facilities. The writing of medical records, the examination and study of pathological specimens, the regular review and analysis of the clinical work and many other procedures of detail and precision, assure a more accurate diagnosis and more efficient treatment for the patient, as reflected in shortened stay in the hospital, fewer complications, and lower mortality rates.

To the physician the approved hospital provides a proper environment in which to do scientific work. He not only has the essential facilities at his disposal but he has a well trained staff to assist him. Through recording the history of his patient, the proper use of diagnostic and therapeutic facilities placed at his disposal, and medical staff conferences and other features in the approved hospital, the physician is able to give better care to his patient and continually improve his own scientific knowledge. Finally, his professional status is improved in being a member of the medical staff of an approved hospital.

To the hospital it is a great advantage administratively, financially and public-relations-wise to be on the Approved List of the American College of Surgeons, published annually. Standardization presupposes a more complete and efficient organization as a whole. The hospital has a better understanding of the best professional care of the patient and how to provide it. Meeting the requirements gives a greater assurance that the hospital is fulfilling its major functions. Its status is immeasurably improved. The intern, the resident, and the nurse seek the approved hospital because they know they can get better training and supervision in their educational program. Furthermore, it is essential that such training be received in approved hospitals in order to facilitate registration in many states.

How did approval of hospitals come about? What is the background of hospital accreditation? What conditions brought this development to fruition, and how has hospital standardization helped to alleviate them?

NEED FOR STANDARDS

The American College of Surgeons was the moving spirit in Hospital Standardization from its inception. Organized in 1913, the College included among its original purposes the betterment of education of the physician and surgeon in the clinical practice of medicine. It was recognized early that good work could not be accomplished by a physician or surgeon in a hospital if the institution did not provide an environment of modern diagnostic and therapeutic facilities, skilled personnel, good medical records, and many other supporting factors.

When the College was established, one of the requirements for fellowship was the submission of 50 complete records of patients upon whom the applicant performed major surgery and for which he was the responsible surgeon. These case records had to contain sufficient data to justify the diagnosis and warrant the treatment and end results. The records were used to appraise the

candidate's judgment and technical ability. Few candidates were able to comply with this requisite satisfactorily because hospitals generally, with the exception of teaching institutions, were woefully lacking in medical records, laboratory and x-ray services for the elucidation and confirmation of diagnoses, and many other services which were essential in the adequate study of the patient.

Motivated by the foregoing condition, the American College of Surgeons undertook a study of hospitals of 100 beds and more throughout the United States and Canada to ascertain their deficiencies or shortcomings and subsequently to determine how to bring them up to at least a minimum or basic level of service. This study, lasting the greater part of two years, revealed surprising conditions, including: Lack of medical staff organization for the supervision and control of professional activities of the hospital; few if any medical records, except in teaching hospitals; no diagnostic and therapeutic facilities in many hospitals; unskilled personnel generally; and many other services concerned in the care of the patient which were lacking or inadequate.

The College was soon thoroughly convinced of the urgency of the situation and this led to careful deliberation by the various state committees and officers of the College, culminating in the establishment of a Minimum Standard for Hospitals in 1917.

THE MINIMUM STANDARD

During the hectic years 1914 to 1918, World War I had generally upset the United States and Canada, and quite naturally the program for betterment of hospitals lagged. The regents of the American College of Surgeons, however, were intent on establishing a Minimum Standard for Hospitals, and the responsibility for this endeavor was given to Dr. Franklin H. Martin and Dr. John G. Bowman, then secretary-general and director, respectively, of the college.

The task of preparing a tentative Minimum Standard for Hospitals was assumed by Dr. Bowman and his associates. Eventually they worked out a comprehensive standard which embraced: (1) Medical staff organization for the supervision and control of professional work; (2) Conferences for the review and analysis of clinical work at regular intervals; (3) Accurate and complete medical records with sufficient data to justify the diagnosis and warrant the treatment; (4) Clinical laboratory and x-ray facilities for the elimination and confirmation of the diagnosis; (5) Elimination of fee-splitting, then a widespread practice.

ORIGINAL PROVISIONS

It was decreed emphatically by Dr. Martin, that the Minimum Standard for Hospitals should be simple, comprehensive and confined to one page of requirements in order not to discourage or alarm hospitals. After much deliberation by all groups interested, the Board of Regents finally adopted the Minimum Standard for Hospitals at their meeting in Chicago on December 10, 1917.

The original standard as drawn up reads as follows:

1. That physicians and surgeons privileged to practice in the hospital be organized as definite group or staff. Such organization has nothing to do with the question of whether the hospital is "open" or "closed"; nor need it affect the various existing types of staff organization. The word *staff* is here defined as the group of doctors who practice in the hospital inclusive of all groups such as the "regular staff," the "visiting staff," and the "associate staff."

2. That membership upon the staff be restricted to physicians and surgeons who are (a) competent in their respective fields, and (b) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatever, be prohibited.

3. That the staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations, and policies specifically provide: (a) That staff meetings be held at least one a month; (In large hospitals the departments may choose to meet separately.) (b) That the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery, and obstetrics; the clinical records of patients, free and pay, to be the basis for such review and analyses.

4. That accurate and complete case records be written for all patients and filed in an accessible manner in the hospital, a complete case record being one, except in an emergency, which includes the personal history; the physical examination with clinical, pathological, and x-ray findings when indicated; the working diagnosis, the treatment, medical and surgical; the medical progress; the condition on discharge, with final diagnosis; and in case of death, the autopsy findings when available.

5. That clinical laboratory facilities be available for the study, diagnoses, and treatment of patients, these facilities to include at least chemical, bacteriological, serological, histological, radiographic, and fluoroscopic service in charge of trained technicians.

Later, as I became charged with the direction of Hospital Standardization, I found certain fundamental weaknesses in the Minimum Standard for Hospitals and proceeded to make a few revisions in the wording of some of the clauses. This process was undertaken while the director-general, Dr. Martin, was in Australia, and although it may have been presumptious, it was imperative that it be done. There was a feeling it was almost sacrilegious to alter a word in this historic document, but when Dr. Martin returned he heartily approved of the re-wording.

The Standard for Hospitals, as it is now stands, more definitely specifies the fundamental requirements.

The present Minimum Standard

About the Author

DR. MAC EACHERN, now director of professional relations for the American Hospital Association, is an outstanding authority on Hospital Standardization. He directed the initial program of the American College of Surgeons from 1923 through October 1950.

includes the requirement that a medical staff member must be a graduate of medicine of an approved medical school, with the degree of doctor of medicine, in good standing, and legally licensed to practice in his state or province. This specification was not included in the original version.

Originally the Minimum Standard stated that in large hospitals, departments could choose to meet separately. This has been eliminated. The old designation of "clinical records" and "case records" became "medical records."

The components of a medical record were altered and expanded to make them more specific and more valuable. Whereas the old standards called for "clinical laboratory facilities," the present version specifies "diagnostic and therapeutic facilities under competent medical supervision." The elements included in these facilities also were expanded and revised.

On October 19 and 20, 1917, state committees and officials of the American College of Surgeons, who had been studying the problem of better institutional care of the sick and injured, met in Chicago, with an agenda covering the following aspects:

1. Number, distribution and classification of hospitals, and relation of the general public.
2. What the medical profession requires in hospitals to afford the patient the best that medical science can offer.
3. Means to bring about the desired improvement in hospitals.

At the conclusion of the meeting they endorsed the Minimum Standard for Hospitals as presented.

In order to put the Minimum Standard for Hospitals into effect, a continuous contact with hospitals was necessary and this led to the suggestion of a field staff and annual visits to hospitals. This program would cost money—the estimate of cost being in the neighborhood of $75,000 to $100,000 per year—and the question of who was to do the work was next considered. Representatives of the American Medical Association indicated they had no funds for this activity as they were deeply involved in medical education. The American Hospital Association had a very limited budget and was unable to undertake the program. After much deliberation it was agreed that the American College of Surgeons, whose interest and leadership in this movement had already been demonstrated, should undertake the responsibility as it had a larger budget, which later was supplemented by a grant of $105,000 from the Carnegie Foundation. This enabled the survey of hospitals to commence in 1918 and it has been carried on diligently and successfully up to the present time.

PIONEERS

Three great names stand out in the early history of Hospital Standardization. These are:

Dr. Franklin H. Martin, then Secretary-General of the American College of Surgeons, and later Director-General.

Dr. John G. Bowman, the first Director of the American College of Surgeons, and later Chancellor of the University of Pittsburgh.

The Reverend Charles B. Moulinier, S.J., leader and chief spokesman for Catholic hospitals of the United States and President of the Catholic Hospital Association.

These men, the real pioneers in the movement, contributed more than they realized. Their work will go down in the annals of history.

(Editor's note: Dr. Malcolm T. MacEachern, the author of this article, equally ranks as an outstanding pioneer and leader in Hospital Standardization.)

In the early development of Hospital Standardization, credit must be given to two very helpful assistants in the persons of Dr. E. W. Williamson and Dr. Thomas R. Ponton, whose deaths in the midst of their active careers were great losses to the American College of Surgeons in this work.

There are many others who deserve the highest credit for their work during the early days, which was exceedingly difficult. In the history should also be recorded the names of Dr. Fred W. Slobe, F.A.C.S., now medical director of the Blue Cross and Blue Shield Medical Service Plans; Dr. Leroy Sloan, F.A.C.P., noted internist of Chicago; and Dr. John A. Breslaham, subsequently in the service of the Veterans Administration.

Early in 1918, the American College of Surgeons was prepared to start the survey of hospitals throughout the United States and Canada.

A group of well-trained young physicians constituted the field staff for the survey. After an indoctrination workshop, they were sent to a few hospitals, accompanied by a senior officer of the college, to make their initial surveys. When successfully completing their trial assignments the members of the field staff were given a schedule of hospitals to be surveyed, covering on the average of one hospital per day, for which they were wholly responsible.

The young physicians on the field staff rendered a good service in the beginning of Hospital Standardization, but as institutions grew more complex it was necessary to employ physicians with more training and knowledge of hospitals.

Increasing attention was given to qualifications of field representatives chosen for survey work. It was necessary that the men be graduates of approved medical schools, have three or four years further study in one or more fields of medicine or surgery, that they possess a considerable knowledge of hospital administration, preferably being graduates of one of the degree courses now offered in several universities, and that they have a good clinical background. Beyond this, emphasis also was placed on personality, tact, diplomacy, honesty, good judgment, and speaking ability.

SURVEY PROCEDURE

In conducting the Hospital Standardization survey, a systematic procedure has evolved over the years which includes the following steps:

1. Compiling a list of hospitals in the United States and Canada of 25 beds and more, excluding hospitals not registered by the American Medical Association.

2. Obtaining preliminary information regarding eligibility of the hospital for the survey and certain other data to warrant the survey and to estimate the interest of the hospital in meeting the requirements.

3. Planning an itinerary for the

field representative covering the hospitals in the area to be surveyed, which shows date of visit, name of hospital and administrator, capacity of hospital, previous rating, etc. The itinerary is worked out with a view to saving as much time and expense as possible

4. Informing the administrator of each hospital by letter in advance of the approaching survey by a field representative, stating purpose of the survey and mentioning data field representative will want to review. The field representative notifies the administrator of the hospital of the exact time of his arrival.

5. Executing the survey in accordance with an established routine, recording the findings on a prescribed form, and confering with members of the governing board, medical staff, or other interested officials of the hospital.

6. Reviewing the findings of the survey, and particularly, conditions to be remedied in conference with administrator and other officials before the report is mailed to headquarters.

7. Analyzing the report of the survey in the hospital department of headquarters preliminary to sending a follow-up letter to the administrator with constructive suggestions and recommendations.

8. Maintaining a close follow-up on the hospital's progress in correcting deficiencies.

A hospital is graded according to one of three ratings:

Fully approved—The hospital having met all the requirements is carrying them out in an acceptable manner.

Provisionally Approved — The hospital having accepted the requirements is endeavoring to put them into effect but for lack of time or other acceptable reasons has not been able to do so in every detail.

Not Approved—The hospital has not met the requirements in an acceptable manner.

If problems temporarily affect the eligibility of a hospital at the time the Approved List is published, the rating of that particular institution may be deferred for further information and observation. The Certificate of Approval is granted to an institution which has been fully approved for a time sufficient to guarantee its continued meeting of the requirements.

Each hospital is considered for rating annually. An institution once approved will not necessarily always remain on the approved list which is published annually.

MANUAL OF STANDARDIZATION

When I officially took over the Hospital Standardization program of the American College of Surgeons, I soon realized that there was more involved than is discussed in the one-page document of the Minimum Standard for Hospitals. Together with my assistant, Dr. Williamson, we resolved that the best care of the patient when ill or injured was the primary objective, and to this end we must equip the physician and his co-workers with the best possible facilities and supporting services.

Based on this over-all objective, the "Manual of Hospital Standardization" was established explaining the specific criteria or requirements. The first edition covered only 10 pages. In subsequent revisions it grew to 118 pages. Before retiring from the American College of Surgeons, I worked on a later unpublished revision which would have covered almost 200 pages.

DEPARTMENTAL STANDARDS

As there are many departments and services involved in the care of the patient, it was concluded that standards should be developed for each one. Consequently, standards were drawn up for the following units:

Anesthesia service; cancer clinics; clinical laboratory; dietary department; eye, ear, nose and throat service; fractures and other trauma; medical library; medical record library; medical service in industry; medical social service partment; nursing service; obstetrical department; outpatient department; pharmacy department; physical therapy department; surgical department, and x-ray department.

FUNDAMENTAL PRINCIPLES

After years of experience in administering a Hospital Standardization program, it was our opinion that the requirements for hospitals to fulfill the intent and objectives of the Minimum Standard for Hospitals, could be summarized as follows:

1. A modern physical plant, free from hazards and properly equipped for the comfort and scientific care of the patient.

2. Clearly stated constitution, by-laws, rules and regulations setting forth organization, duties, responsibilities, and relations.

3. A carefully selected governing board having complete and supreme authority for the management of the institution.

4. A competent, well trained executive officer or administrator with authority and responsibility to carry out the policies of the institution as authorized by the governing board.

5. An adequate number of efficient personnel, properly organized and under competent supervision.

6. An organized medical staff of ethical, competent physicians for the efficient care of the patients and for carrying out the professional policies of the hospital, subject to the approval of the governing board.

7. Adequate diagnostic and therapeutic facilities with efficient technical service under competent medical supervision.

8. Accurate and complete medical records, promptly written and filed in an accessible manner so as to be available for study, reference, follow-up and research.

9. Group conferences of the administrative staff and of the medical staff to review regularly and thoroughly their respective activities in order to keep the service and scientific work on the highest plane of efficiency.

10. A humanitarian attitude in which the best care of the patient is always the primary consideration.

SURVEY AND REPORTS

The survey report of the field representative increased in content as the program of Hospital Standardization progressed. In the beginning all the data collected could be recorded on a 5 x 8 card. As time went on it became necessary to use a four-page 8 x 11 report which

(Continued on page 219)

A reporter's notes on hospital care

LUCY FREEMAN

I had never been the patient--merely the reporter, the visitor. . .

ALTHOUGH A REPORTER of hospital news for four years for the world's finest newspaper, I blush to confess I had never been inside a hospital as patient.

Oh, I had walked down corridors with administrators as they explained courteously and carefully why hospital care cost more these inflationary days. I had shuddered as we passed operating rooms and smiled in delight at the fragrance of mammoth kitchens.

I had visited relatives and friends in hospitals, never daring not to. I would skulk in bearing flowers or candy (depending on the type of illness) and pray the sufferer wouldn't be watching the clock and thus know I was watching for the time when the visiting period could end. Somehow, I felt threatened, as though life were difficult enough without this added burden. I knew I was scared to death to be inside a hospital. All I wished was to bolt the place and return to the safety of a typewriter-ridden world.

To get psychological, when in hospitals I was fighting especially hard against my own unconscious fear of sickness and death, even though for me, this was not a real threat. I had never been the patient —merely the reporter, the visitor.

The late Dr. De Witt Stetten, a noted surgeon who operated at Lenox Hill Hospital, New York City, would tease each time he saw me. "Ah," he would joke, "You're the only one of your family I haven't operated on. I'll get you yet!" The wonderful De Witt died last year before he had a chance at me. I hope he is chuckling, though, to know that Lenox Hill Hospital —and its administrator, John Hayes— finally got me.

I wish I could say that I entered the hospital doors bravely. Rather, I staggered in as though my suitcase were loaded with rocks instead of lingerie. I was early, as I am early for everything (would be even for my execution). It was 7:30 A.M. I perched on my suitcase in the dimly lit, silent hall, ignoring the comfort of chairs. I tried to talk my unconscious into talking my conscious into some minor display of courage.

"Listen, idiot," part of me said to part of me. "You know you're scared silly even of daylight. People scare you. Deadlines scare you. This may be a little more serious than daily living, but not much more. Get up off that suitcase and go into the admitting office."

Logic triumphed over weak legs. Before I knew it, I was high up in the private pavilion, alone in a wide, airy corner room with two different views of the city I had reluctantly left behind. A brisk, attractive nurse gently told me what I was expected to do.

"Get undressed, get into bed and rest," she said.

I did everything except "rest." I could not stop worrying about the hypodermic shots and the anesthetic. All my life I dreaded needles stuck into me. Not only was there something undignified about some stranger plunging a needle into you but it hurt, too.

When the nurse returned with a hypodermic to quiet my nerves, I nearly volunteered to go through the entire business without drugs. Luckily I held my tongue.

I kept waiting for her to hurt. She didn't. The next shot, just before the operation, didn't hurt either. Later there was penicillin. I didn't mind that. By the time I left the hospital I had lost my fear of injections.

"Something's happening, sister," I muttered to myself, relaxed and sleepy after the first one. "You thought it would hurt and it didn't. Could be you're wrong?"

The moment I dreaded most, the moment that whirlpooled through my mind days before, was the one during which I saw myself loaded on a stretcher and taken to the operating room. "That I will never be able to stand," I thought. "That is when I will flee the hospital, white gown and no lipstick notwithstanding."

"The" moment arrived when a child walked in. At least she seemed but a child, although in my drugged stupor I may have exaggerated her infancy. She was pushing a bed.

"You get on this," she explained, helping me out of my comfortable bed out of which I did not want to get.

I lurched onto the cart. "*You're* going to push *me*?" I asked incred-

Miss Freeman is a member of the news staff of the New York *Times* and is a specialist in news of hospitals, social welfare and mental health. She is the author of "Fight Against Fears" (New York City, Crown Publishers, Inc., 1951).

ulously. "I weigh twice as much as you."

She said not a word but expertly maneuvered the movable bed down the corridor. We passed a group of visitors waiting to see patients. They stared at me in mixed horror and relief; relief that they were not on the cart, as I had felt relief on former visits when seeing others trundled off for operations. Now it was my turn, however unwilling I might be, to take center of the stage.

Into the elevator, upstairs, and all the time getting groggier and groggier from the hypo. "The small operating room," I heard someone direct. "Huh," I thought resentfully, "I'm not even important enough to have a large operating room." I had pictured myself in the middle of an amphitheater with eager interns and nurses in the balcony.

I was wheeled into the "small" room. A handsome man, wearing an operating-room mask, entered. From what I could see of his face—eyes and eyebrows and hair—he looked like Clark Gable. He started fussing with the anesthetic. I wouldn't look at the apparatus. I didn't dare. For all I knew it held wine instead of sodium penthatol or whatever was used.

Then I really became terrified. This was it. I hadn't escaped.

I turned to Clark Gable, wailed, "This is the first time I've ever been in a hospital!"

"It's all right, darling," he said, wiping the perspiration from my forehead. "I know how you feel."

I shall never forget that kindness. He *knew* how I felt. Therefore, he wouldn't hurt any more than he had to.

"This will sting just a moment as it goes into your arm," he explained.

"You're going to knock me out?" I asked fearfully.

"Not knock you out—just help you drift off to sleep," he said. I felt a slight prick on my arm. I waited a few seconds.

"I'm not drifting yet," I complained.

I heard laughter from some nurses who had come in. I saw my doctor had entered and I started to say, "Happy New Year." The words wouldn't come out.

"Why can't—" I thought. Then I opened my eyes weakly. I felt thirsty. The nurse who first took care of me, who belonged back in my room, was standing beside me.

"Where am I?" I asked, no more original than the movies.

"You're in your room," she said, patting my head.

I can't be, I thought. What happened to time?

"What time is it?" I asked her, not believing it was over.

"One o'clock," she said.

From then on it was clear sailing. I had a slight headache and wanted only to sleep; a great wave of relief dulled me. No one could hurt me now.

During the next few days, I reveled in the splendor of being cared for as I had not been since an infant. If all hospitals are like Lenox Hill in spirit and substance no patient need fear.

Not in 30 years, perhaps never, had I felt such peace and inner well-being. Never had there been the chance to take so many deep sighs and realize that the most important thing about life was, after all, that we are alive. The petty irritations of existence outside the hospital took on their proper pygmy size.

I thought of the attention I was given. Bathed by someone else. A button within a whisper's reach should I want something. Food so delicious I ate all of it even though I did not feel hungry. Penicillin to insure against infection. Drugs to help me reach sleep.

"All the money in the world couldn't pay for this feeling," I thought. "To be made to feel so safe and comforted at a time of crisis—how can one compute fulfillment of this need in terms of dollars and cents?" Hospitals do draw the line, charging nothing for psychological care.

When the time came, I left with head held high. I walked through the corridors proudly, feeling that for the first time I had a share in the hospitals about which I had written so many words. I knew, at last, that hospitals exist to help men live, not die.

I shall write about hospitals with a different feeling in the future.

. . . When the time came, I left with head held high, feeling I had a share in the hospitals about which I had written many words.

An idea for HOSPITAL DAY

A program tried with great success in Elgin, Ill., could answer your question of how to observe National Hospital Day differently this year.

SENIOR VISITATION Day in Elgin, Ill.—an outgrowth of Business - Industry - Education Day—doesn't mean just learning about assembly lines. It means finding out what goes on in the hospital, as well. For high school seniors who made the inspection tour this year, it meant a new awareness of the meaning and complexity of health care . . . a new insight into career possibilities.

Sherman Hospital, along with 30 business and industrial organizations in precision-instrument-manufacturing Elgin (population 44,000) was given a thorough scrutiny by high school seniors studying economics and social problems. Plans were laid in advance by the Elgin Association of Commerce, representatives of industry, students and teachers. More than 500 students from four high schools took part and were divided among the plants to be visited. Sherman Hospital drew 25.

One afternoon late in February, cars supplied by the hospital delivered the 25 to its doors promptly at 1:30. Administrator Charles A. Lindquist and department heads—the pressure of morning duties behind them—were ready. The hospital's staff of 300 had been alerted to the role of multiple hosts.

The 25 seniors, already primed by discussions in the classroom and a short history of the hospital mailed to them in advance, were eager to find out how the hospital "business" worked. Sherman Hospital's 200-bed modern, fire-proof plant—part of it less than two years old—offered an ideal example for their study.

Separated into groups of five, the students were escorted by the administrator and department heads through the various sections of the hospital. In the physical therapy department they watched a 2½-year-old polio patient—a litle girl once completely paralyzed—given a knee massage by a skilled therapist, the final stage in the child's treatment. In the x-ray department they marveled at the massive machinery of the deep therapy machine and its powerful, healing rays. In the laboratory they were impressed by the precision of the pathologist's delicate work.

Going on to other floors they peered through the nursery window, giggled over the faint stirring of the babies in the warm cocoons of their bassinets . . . strained to get a glimpse at the baby in the incubator. They visited in turn the seven operating rooms . . . saw the compact efficiency of the pharmacy . . . took note of the brisk, crisp nurse busy at her station or quietly hurrying to answer a patient's call.

Sherman Hospital had no secrets by the time the tour ended. The gleaming kitchen with the evening meal in process, the laundry, the power plant . . . all received a careful going over. The students also took a good look at the school of nursing—run in conjunction with Elgin Community College—and appraised the nurses' residence.

By 2:30 the first group had finished its tour and was relaxing in the comfortable first-floor lounge. As other groups arrived, they were joined by department heads who had not accompanied a tour.

The time for questions had come. How many people did the hospital employ? How many in the laboratory? The x-ray department? The kitchen? What kind of pay did these people receive? How many hours did they work?

There were other questions that showed some were wondering about hospital work: How long did it take to become a nurse? Did the hospital train anyone but nurses? How did an administrator get to be an administrator? Was there a course for that, and where?

Too soon, it was 3:30 and Visitation Day at the hospital was over. Successful? According to Mr. Lindquist: "Very." And for three main reasons. The students learned what the various departments of the hospital are, and what goes on in them; they learned about interesting careers, one of them nursing (in industrial Elgin, student nurse recruitment is a problem); they became more health- and hospital-minded. "Public relations-wise," he said, "I don't know what we could have done that would have carried so much impact."

A questionnaire circulated to the students and not yet tabulated will give the final answer as to what they themselves thought and felt, but from all appearances annual Senior Visitation Day had become an Elgin institution.

Other hospitals, in communities that may not have senior visitation days, would do well to follow Sherman Hospital's example and show the young people of their town not only what their hospital means to the community but what it can mean to their own future. National Hospital Day presents an opportunity for such a program.

Suggested slogans for National Hospital Day 1952 are *"The most important building in town—your hospital"* and *"Get to know your hospital—it's your friend."*

Comparing patient costs in wards and private rooms

E. DWIGHT BARNETT, M.D.

FOR MANY YEARS, there have been discussions about the cost of patient care in wards as compared to the cost of care in private rooms. But until recently little actual study on a cost analysis basis had been done on the two kinds of services.

At the last annual meeting of the American Hospital Association, for instance, Dr. Fred G. Carter read a paper entitled, "A Formula for Calculating Hospital Charges on a Cost Basis." Dr. Carter was speaking with reference to the establishment of proper payments by Blue Cross. He mentioned, however, that an accurate relationship of costs between wards and private rooms had not been established and that he was using, therefore, the old arbitrary figures of wards being maintained on the basis of 90 per cent of cost, semiprivate room beds on 100 per cent, and private rooms 110 per cent. This formula assumes that there would be a 20 per cent difference in cost between a ward bed and a private room.

We, too, had been having a serious problem with both Blue Cross and commercial insurance coverages in our Michigan association because of the variation in rate structures in the various hospitals as to wards, semiprivate and private rooms. Blue Cross paid hospitals 102 per cent of cost or charges, whichever was least, while commercial insurance companies paid charges according to the accommodations used by the patient. It became very evident that where Blue Cross was paying 102 per cent of cost and the ward charges were several dollars a day less than these costs, Blue Cross resulted in paying 102 per cent of the average cost for all services, while commercial insurance companies and the private patients were paying actual charges.

The following two examples show the disadvantage of Blue Cross if it has to pay on a cost basis when the hospital sets its rates at less than cost. Hospital "A" had a ward charge of $8, semiprivate $12, private $14 and up. Its average cost, plus 2 per cent as submitted to Blue Cross, was $20.50 a day. Blue Cross paid this hospital $20.50 a day, while the private patient in a ward paid $8 plus $11 a day, which was the average charge for extras. This means that a total of $19 a day was paid by commercial insurance companies for the average patient and by private patients, as against $20.50 by Blue Cross.

Hospital "B" had a ward rate of $12, semiprivate rate of $13.50, and private rooms at $15 plus. The average cost to Blue Cross was $21. For ward patients, Blue Cross paid this hospital $21 a day, while commercial insurance companies and private patients paid $12 plus an average of $7 a day for extras, or a total of $19 a day.

Most of the other hospitals in the community used variations of these two rate plans and thus it became important to find out if they were related to the true cost of service in the two categories. We tried to justify the varying rate structures according to the accounting systems of the institutions, but found there was no place in which the cost analysis system was set up so

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COMPARATIVE CHARGES

Service	Ward	Private	Increase or Decrease Private over Ward
Admitting	.142	.159	.017
Information	.053	.069	.006
Plant (heat, light, power)	.430	.635	.205
Maintenance bldgs. & grounds	.218	.391	.173
Housekeeping	.730	1.079	.349
Laundry & linen	.390	.546	.156
Communications	.042	.048	.006
Textile manufacturing	.010	.012	.002
Nursing service	6.330	6.671	(.289)
Patient food service	3.886	4.024	.138
Physicians' service	.031	.031	—
Central supply	1.143	.966	(.177)
Medical records	.141	.169	.028
Medical social service	.051	.002	(.049)
Operating rooms — majors	.997	.895	(.102)
Operating rooms — minors	.242	.242	—
Anesthesia	.294	.282	(.012)
Pharmacy	1.041	1.322	.281
Physical therapy	.030	.047	.017
Blood bank	.195	.171	(.024)
Inhalation therapy — tanks	.173	.169	(.004)
Inhalation therapy — bulk	.133	.113	(.020)
Laboratories	.678	.834	.156
Electrocardiography	.028	.051	.023
Electro-encephalography	.006	.015	.009
Basal metabolism	.011	.020	.009
School of nursing	1.118	.462	(.656)
Intern and resident education	.665	.582	(.083)
Undistributed overhead & depreciation	.918	.782	(.136)
TOTALS	20.723	20.779	.056

BY COMPARING charges for both ward and private room patient service in Harper Hospital, the above chart brings out the actual difference in costs between the two kinds of service.

that an accurate accounting of the costs going into ward care, semiprivate care, and private care could be calculated. It was determined, therefore, that we would set up in Harper Hospital a study to determine accurately the cost of caring for patients in ward areas and private room areas, these being the two extremes in service.

Harper Hospital already had developed a departmental cost analysis system which supplied quite accurate figures on the cost of caring for different types of patients, such as surgical, medical or obstetrical. But this system could not be used to find the cost of ward and private care, so we had to make it a special project. A study was made for six months beginning with October 1950 and ending in April 1951. The accompanying table shows the per diem cost of the various departments and services in the hospital for ward and private room patients.

It should be noted that the costs of the various departments which are applicable to wards and to private rooms vary with some services being higher in cost to wards and some services higher in cost to private rooms. But when all of the costs are added up, the cost to the patient in the ward is $20.72, while that to the private room patient is $20.78, a difference of only six cents day. This should indicate that there is no basic difference in the cost of operating ward, semiprivate or private services.

Rate structures which are based upon differentials between ward, semiprivate and private accommodations (approximately 10 to 20 per cent) are obviously not fair to the hospitals. Because of these structures, hospitals will be selling many of their services at less than cost to insurance companies and to patients who are quite able to pay for the full cost of service, and they will be needlessly overcharging patients in private rooms by an amount sufficient to care for these same private and insurance cases.

I hope our hospitals will study these figures with reference to their own rate structures, to see if we cannot develop rate structures more in keeping with the present high percentage of prepayment cases in our hospitals.

Day nursery helps nurse-mothers

THE IDEA of a day nursery for the children of employed nurses began with the problem of Mike. He was a lively two-year-old whose young mother, a widow and a graduate nurse, needed financial assistance for herself and her son. She was unable to work, however, because she could find no one to take care of Mike. So she went to see the director of nursing service at Mercy Hospital in Springfield, Ohio, where they lived.

After hearing about her problem, the director of nursing service realized that there must be other nurses in a similar predicament.

At this time, the director of nursing also had the problem of filling the nursing staff of a newly-constructed hospital. She was having a hard time because of the shortage of nurses, but after going over the problem of Mike's mother, she realized that here was available a group of unemployed nurses. The ideal thing to do, she thought, would be to find a solution which would resolve both problems.

After much deliberation, she conceived the idea of a day nursery. She suggested the plan first to Mike's mother, who approved instantly, and then presented it to the hospital officials. They also okayed it, and went on to suggest that she establish it right in the new hospital. The nursing director agreed and chose for the nursery, the location that originally had been intended for the occupational therapy department.

Here was a spacious room with terrazzo floor, pale green tile walls and fluorescent lighting. A large sink and set-in lockers were part of the stationary equipment. To this she added a refrigerator, an electric fan, and comfortable chairs for the attendants, as well as a sturdy kindergarten table and small chairs for the children.

Adjoining the nursery was a somewhat smaller room, half partitioned in glass, which was set aside for the nap period. In it were installed five cribs and individual lockers. A third room, also interconnected, is now a nursery office.

At first the director of nursing service had trouble finding someone to take charge of the nursery, but finally she secured an experienced nursery school attendant. Together, they worked out a balanced program for the development of both infants and toddlers. Here is a typical day:

7:00 A.M. to 9:00 A.M.—games and drawing.
9:00 A.M. to 9:10 A.M.—lunch.
9:15 A.M. to 10:00 A.M.—singing games.
10:15 A.M. to 11:30 A.M.—outdoor games and playground exercise.
11:45 A.M. to 12:15 P.M.—dinner.
12:20 P.M. to 3:30 P.M.—nap.
3:30 P.M. to 4:00 P.M.—games and reading hour.

For sanitary purposes and as a means of developing good hygienic habits, a special washroom has been set up for the children. Each toddler is furnished with an individual basin, towel and wash cloth.

The nursery is open from 7:00 A.M. to 5:00 P.M. every day including Sunday, and its accommodations are available to any graduate nurse who is on duty in the hospital. Since it first opened, the number of children at the nursery has increased from seven to 16.

Recently the nursery developed another purpose. Students enrolled in the hospital's program for practical nurses spend a part of their training time working in the nursery and thereby learn how to handle and care for very young children.

Most encouraging of all is the number of nurse-mothers utilizing the nursery who report they can go to work with a carefree attitude because they have found that the care and training their children are getting in the nursery is more than satisfying.—This goes for Mike's mother, too, who started the nursery idea in the first place.—*Sister Mary Cecilia, R.S.M., administrator of Mercy Hospital, Springfield, Ohio.* This article is adapted from her entry in the "What's An Idea Worth?" contest, sponsored by the American Hospital Association in 1951.

a new approach to

CORPORATE GIFTS

W. H. MARKEY JR. AND A. G. STOUGHTON

THE TIME-HONORED pattern of philanthropy by corporations in giving money to hospitals has sometimes savored of the advertising pages in high-school year books labelled "Compliments of a friend." In present day sales language that kind of advertising is known as the "brush off." It got a few dollars for the school but paid no dividends to the donor.

Much corporate-giving to schools, colleges, hospitals and other tax-free agencies has been based in part on this brush off theory or, at the very best, is considered to be a necessary community charity and so budgeted by the directorates of corporations. The total corporate budget for all "charity" has never been substantial.

Under Internal Revenue laws today, contributions made to tax-exempt "educational, scientific and welfare" agencies by corporations reduce corporate taxes, but there are relatively few big businesses which now take full advantage of this provision. In only one year did the total exceed 1 per cent, when by law, corporations are permitted 5 per cent of their net income as contributions. Despite the "Battle for the Dollar," as *Time* magazine recently headed an article on this same subject, gifts for educational, scientific and welfare purposes still lag far behind the need for them and usually are uninspired and without plan.

The argument for more realistic corporate-giving challenges American business to get out of the horse and buggy age in its benefactions and not only take advantage of long term planning but expect a return on its investment in philanthropy. Only a few corporations, however, have set out to do specific jobs with tax deduction dollars—jobs that spell additional financial as well as good will return for the corporations.

There would appear to be a contradiction in terms between philanthropy and investment, but if the first is carefully planned it easily becomes the latter.

Hospitals today are in competition with foundations, universities and others soliciting tax-free gifts. Hospitals have a decided advantage—if they wish to be realistic about it—for could they not be classed as educational, scientific and welfare institutions all in one?

The frank approach to business sells tax deduction but shuns the

weak argument of community responsibility and good will return only. Business is becoming allergic to emotional appeals and "compliments of a friend" advertising. Business likes—and deserves—a return on investment. Hospitals can offer dividends on investments in the hospital that will pay off in far more than good will. Public relations directors and business executives are receptive to direct approaches by hospitals which offer a new type of use for their money.

This new approach to business begins with the hospital's honest appraisal of needs and projects to utilize the business dollar. Specifics should appear when the administrator sits down with his board and goes to work on the preparation of a list of past donors to the hospital, adds to the list new businesses in the area, reviews all hospital activities and unmet needs, and comes up with a new list keyed to specific projects of need *and* to the particular corporation or corporations in the community that should sponsor each specific project. The authors have prepared the following 21 projects as suggestive of others that will grow out of individual hospital needs. Each hospital, however, must relate its projects to its own community potentials.

Automobile companies: Interns' and residents' libraries—small general and magazine libraries in interns' and residents' quarters. (Named after company.)

Book companies or other businesses: Patients' libraries and library services. (Company name on each book.)

Dairy and canned milk companies: Equipment and supplies for newborn infant formula rooms. Establishing services, training of personnel, etc., for care of premature infants. (Name of sponsoring company publicized to mothers of hospitalized infants and to general public.)

Department stores: Student nurses' loan funds—fixed funds from which student nurses borrow, without interest. (Name of donor associated with fund, e.g., "Hub Store Loan Fund.")

Drug manufacturers and distributors: Setting up laboratories or pharmacies, bearing name of company. (Many small hospitals do not have these departments.) (Pharmacy labels and other material marked with name of company.)

Film companies: Recreational therapy films, training films, film libraries (Each film identified with name of company.)

Florists: Student nurses' scholarships, and nurses' loan funds. Flower vases and flower arrangement assistance. (Name of company identified with the project.)

Food manufacturers and distributors: Scholarships for hospital dietetic or purchasing personnel attending short-term educational institutes. (Diploma shows name of company.) Dining rooms or snack shops, bearing name of company, for hospital personnel, visitors or medical staff. Nutrition clinics for paying patients.

Furniture (office and living room) companies: Furniture for lobbies and waiting rooms. (Appropriate plaque on each piece of furniture.)

Furniture (physicians' offices) companies: Furniture for private physicians' offices, dressing rooms, etc., in hospital. (Appropriate plaque on furniture.)

Infants' service and products companies: Booklets on home care and feeding of the newborn, identification tapes or beads, souvenir footprint cards, etc. (Items marked with the name, and appropriate message, of the donor company.)

Insurance (fire and casualty) companies: Fire prevention and safety programs. (Name of company publicized to patients, visitors and general public.)

Printing and paper companies, publishers: Booklets for visitors or patients. Paper tray mats and napkins. Stationery placed at bedside, in lounges, and so forth. Setting up medical libraries. (Each booklet or other item imprinted with name of company.)

Radio and television equipment companies: Television sets in waiting rooms for fathers-to-be and in other waiting rooms. (Appropriate plaque on each set.)

Shoe manufacturers and retailers: Equipment and supplies for orthopedic or physio-therapy departments for paying patients. Research funds for polio, spinal meningitis and other crippling diseases. (Departments and projects identified with name of company.)

Soap companies: Scholarships for hospital personnel attending laundry or housekeeping educational institutes. (Institute diploma shows name of company.)

Taxicab companies or other businesses: Financing preparation of patients' and visitors' information booklets. (Company name and appropriate message on each booklet.)

Textile manufacturers and retailers: Linen supply rooms. Scholarships for hospital personnel attending laundry or housekeeping educational institutes. (Diploma shows name of company.) Linens for patients' rooms. (Each piece marked "Gift of Blank Linen Company.")

Theatres: Recreational therapy equipment or department.

Any business: Routine chest radiography, diabetes and other mass screening programs. (Patient given card, with name of sponsoring company and appropriate message thereon, announcing examination findings.)

Any business: Financing nurse aide (male and female) volunteer training programs and other hospital training programs. (Individual given certificate, with name of sponsoring company and appropriate message thereon, at time of graduation from course.)

The hospital has to offer to business—any business—four measurable segments of potential customers. They are first the *paying* patient; second, the thousands of visitors to the hospital each year; third, the entire staff, both professional and non-professional, and, fourth, the general public reached in many direct and indirect ways by hospital publications and word of mouth advertising.

Some products or services of businesses are bought by all these four groups, others have a sales appeal only to limited customer groupings but business is ever alert to new approaches to new customers. The ingenuity and initiative of the individual hospital is challenged to tap these springs of revenue. Further, business "know how" can be challenged to produce

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projects in cooperation with the hospital. Executives of business would like to "father" and support their own ideas if given the chance.

Tax deductible donations to hospitals by business actually result in tax savings to business and part of the cost of the expenditure is absorbed by the federal government. The Revenue Act is designed to stimulate giving, on the theory that if government does not forgive taxes on a proportion of gifts, government itself must provide subsidies for education, health and similar functions that are regarded as essential to society.

TAX SCALE

Under a federal corporate tax rate of 52 per cent today, $1 donated will take 48 cents out of profit and 52 cents out of taxes. A sliding scale, keyed to excess profits, goes as high as 18 cents off profit and 82 cents off taxes. Expenditures for good will, advertising and related returns are bargains far below cost at these rates. Business also can use the device of specially created trusts through which to make expenditures to hospitals. This permits funds to be set aside in prosperous years to become available for the maintenance of a program in lean years.

Time magazine called the private corporation the last great reservoir of wealth outside the federal government. In this new approach to business, however, partnerships and sole proprietorships also should not be overlooked. These are permitted expenditures up to 15 per cent, instead of 5 per cent, of net income before taxes and tax savings to them are substantial.

Industry is on record in many observations by its spokesmen on the subject of philanthropic gifts. Perhaps the most outspoken was a steel executive who said recently that "No contributions are made to causes as such, no matter how good they are, unless we can figure some direct return to us." In other words, there are strings attached to business giving—and the hospital that can provide the strings and tie them to the hospital will get business dollars in far greater volume than ever before to improve and further the service rendered by the hospital to the community.

Using a vegetable crisper for storing medicine vials

TO FACILITATE easier, faster, and more accurate selection of medications and pharmaceuticals, White Memorial Hospital in Los Angeles developed the idea of keeping medicine vials in an ordinary refrigerator vegetable crisper.

Fitted inside this vegetable crisper is a white enameled board about two inches thick. The vials are stored in holes one and one-fourth inches in diameter and one inch in depth which were drilled in the board. To further simplify location of the bottles, metal clips, in which identifying labels are inserted, are attached to the board alongside each hole.

By using this device, the pharmaceuticals are kept cold and free of contamination, while at the same time the vials are prevented from tipping. The vegetable crisper slides in and out of the refrigerator with very little effort, and the whole unit is easily kept clean.

This idea was submitted by Miss Maxine Atteberry, R.N., director of nursing service, and Harold Ermshar, manager, White Memorial Hospital, Los Angeles, Calif., as an entry in the "What's An Idea Worth?" contest for 1951, sponsored by the American Hospital Association.

(Projected from data submitted to the American Hospital Association by 3,437 hospitals, February 1952)

Personnel group	*Currently employed*	*Current job vacancies*	*Additional Personnel needed in next 5 years*
Dietitians	10,262	3,334	5,392
Laboratory technicians	24,979	3,737	10,528
Medical record librarians	5,303	2,145	3,078
Medical social service workers	5,062	2,280	3,507
Occupational therapists	3,624	2,265	2,897
Physical therapists	5,219	1,940	3,323
Practical nurses	76,502	29,099	41,833
X-ray technicians	12,961	2,127	6,422
	143,912	46,927	76,980

Critical shortage of personnel

——————results of a survey

THERE IS A shortage of more than 45,000 professional and technical personnel in our hospitals today, according to a survey just completed by the American Hospital Association. This figure does not include graduate nurses.

Furthermore, within the next five years, nearly 77,000 additional persons in these skilled fields will be required if hospitals are to continue to provide quality care to patients.

The purpose of the survey, submitted to 6,788 hospitals in the United States, was to determine current employment, job vacancies and future needs for dietitians, laboratory technicians, medical record librarians, medical social service workers, occupational therapists, physical therapists, practical nurses and x-ray technicians.

Impetus for the special study was given by the Health Information Foundation (a national nonprofit organization interested in the over-all health needs of the nation) which recently expressed a willingness to consider sponsoring a nationwide recruitment program for health personnel.

Since the foundation's assistance would be of great help in solving the problems inherent in the critical shortage of skilled personnel both within the hospitals of the country and in the general health field, the Board of Trustees of the American Hospital Association wholeheartedly endorsed the proposed recruitment project and offered the Association's support in it.

Before embarking on such an ambitious program, the foundation needs reasonably substantial figures that will disclose the major areas of personnel shortage. The foundation also desired estimated figures of personnel needs for a five-year period. For that reason, the Association initiated its special personnel study.

The Association survey defined "qualified professional and technical personnel" as "those individuals working in the hospital who have had formal training courses or those who have had sufficient experience to be considered trained workers by their professional organizations or other form or registration or accreditation."

Three questions were asked in the Association questionnaire. The first was for the number of qualified personnel in the various specialized areas who were currently employed in the hospital. The second question sought the number of additional qualified personnel that hospitals would employ if the personnel were available. Hospitals were asked to base their answer to this second question on the actual number they needed to provide adequate service rather than upon the number that may have been authorized by government authorities or the number dictated by

Average Number of Qualified Professional Personnel Employed Per Hospital—1952

Type of service and size of hospital	Dietitians	Laboratory technicians	Medical record librarians	Medical social serv. workers	Occup. therapists	Physical therapists	Practical nurses	X-ray technicians
Gen. & Special Hospitals								
Under 50 beds	.41	.98	.37	.05	.05	.16	5.04	.81
50 to 99	.84	2.02	.85	.09	.06	.27	8.73	1.36
100 to 199	1.63	4.07	1.32	.33	.12	.70	10.45	2.35
200 to 299	2.98	7.77	1.49	1.01	.23	1.43	12.93	3.45
300 to 599	4.94	12.20	1.81	2.53	.62	2.30	18.03	5.00
600 to 999	7.43	18.26	1.15	4.78	2.05	3.40	26.31	5.97
1000 beds and over	9.57	25.32	.89	8.91	6.46	8.07	53.21	10.36

their personal financial situation.

The final question asked for an estimate of the additional needs for qualified personnel anticipated by the hospital over the next five years. This figure was not to include the personnel currently needed, as reported in the second question.

The shortage of graduate nurses was not investigated, since inquiries in this field had already been made by the American Nurses Association. Furthermore, no exploration was made into the possible need for untrained workers, although in some areas of the country this presents a decided personnel problem in hospitals. Pharmacists, another major technical group employed by hospitals, were not included in the study since there seems to be a sufficient number of them to meet hospital's needs.

Questionnaires were returned from a total of 3,837 hospitals, 400 of which were federal institutions. A projection of the approximately 56 per cent of the hospitals who returned the personnel query revealed that all hospitals were currently employing some 143,912 persons in the "qualified professional and technical personnel" category. There is an estimated shortage of 46,927 persons.

Since the national nursing organizations have estimated that some 50,000 additional graduate nurses are needed, a total of 127,000 more skilled personnel are required to meet the needs of our hospitals alone within the next five years.

These figures were subjected to inquiry and discussion at a meeting called by the Health Information Foundation on February 20. Representatives of all of the professional and technical groups under study were present.

Representatives of these major professional groups outlined the particular problems faced by their members. They discussed all phases of recruitment and training.

According to reports, virtually all of the organizations are devoting considerable time to recruitment activities. It was recognized however, that these recruitment efforts were necessarily limited in scope and, in general, markedly strained existing resources of those associations.

It was agreed, furthermore, that the most successful recruitment program has been that conducted by the nursing profession through the cooperation of the Advertising Council, the Committee on Careers in Nursing, and with the financial assistance of the United Defense Fund, the American Hospital Association, the American Medical Association, various voluntary agencies and supported broadly by the general public.

Some of the problems inherent in any valid determination of personnel needs in these fields were disclosed when representatives of the American Dietetic Association stated that approximately half of their members work outside the hospital. On the strength of that statement, the group assumed that the shortage of dietitians might actually be almost double the figure reported by the hospitals in the Association inquiry.

On the other hand, and to illustrate the complexity of the problem, relatively few medical record librarians are employed in doctors' offices and with other health agencies; they work primarily in hospitals. The shortage of this group of workers, as estimated by the hospitals, more nearly represents the total requirement.

At present the Health Information Foundation, in cooperation with various other associations in these fields, is obtaining additional figures on personnel needs that can be incorporated with the statistics reported by hospitals. The foundation is seeking the total need inside and outside the hospital for personnel in the professional and technical categories before further developing its comprehensive recruitment program.

Auxiliary Recognition

with emblems and membership pins

SPRING BRINGS annual meetings to many women's hospital auxiliaries, and new officers and plans for the year ahead.

An innovation for these occasions this year will be the presentation of sterling silver pins to the outgoing presidents and recognition or general membership pins, also in sterling, to the hard-working individuals in the group. The pins, pictured at right, and the woven emblem, shown at left, recently were prepared by the Committee on Women's Hospital Auxiliaries for use by all the auxiliaries with Type V membership in the American Hospital Association. The pins and emblem carry the Association seal.

PRE-ADMISSION REGISTRATION

assures better collections

DANIEL G. GILL

HOSPITALS HAVE BECOME increasingly concerned in recent years over mounting receivables and bad debt losses. Even though voluntary hospitals are nonprofit, charitable institutions, stricter credit policies should be adopted to prevent hospitals from being imposed upon, especially because of the steady rise in operating costs. Moreover, since large estates, contributions and high returns on investments are becoming things of the past, these increased costs must be met to an ever-increasing degree by collections from patients.

It seems generally agreed that the best way to do this would be to develop hospital credit and collection policies like those of business firms. One of these which rapidly is becoming widespread is the policy requiring individuals to make advance payment at the time of admission. Requirements vary considerably, of course, because of the unpredictability of the size of the hospital bills.

Experience has shown, however, that few patients are prepared to pay at the time of admission. Furthermore, since the first interview is invariably conducted when the patient reports for admission, it is practically impossible to enforce such a policy. Failure to pay when admitted frequently leads to nonpayment during hospitalization or at discharge and is the major underlying cause of the inflated accounts receivable and bad debt losses prevalent today.

This article is adapted from an address presented by Mr. Gill, credit manager of Pennsylvania Hospital, Philadelphia, at the American Hospital Association's Institute on Credit and Collections in Atlantic City, May 1951.

In the business world, requiring down payments dates back to the inception of installment buying. Today, down payments in many transactions are compelled by federal law. The fact that a high rate of installment sales continues is sufficient evidence that the general public is able and willing to meet this requirement.

Hospital patients are the same people who support the idea of advance payment in their routine business dealings, yet hospitals have difficulty enforcing this policy. It becomes the hospital's duty, therefore, to familiarize the public with the requirements and benefits of such a plan. The mere adoption of this policy, even though it is put in writing and staff doctors are requested to cooperate with it, is not enough. Pre-admission attempts to achieve an understanding between the individual and the hospital probably would help to eliminate this problem.

In a retail business, the credit office interviews the customer in advance of rendering service. If investigation reveals that the individual's paying habits are poor, or that his income is insufficient to make payments, he is required to pay the full amount in advance in order to receive the merchandise. Hospitals, however, cannot be so matter-of-fact because they are dealing in human welfare, very often in life or death.

It thus becomes obvious that hospitals will have to establish a plan which will afford the opportunity of interviewing patients in advance of the date of admission. Naturally, this plan could not cover accident cases and other emergencies. But statistics show that these cases represent the minority and that most patients know long beforehand if and when they will be in the hospital.

PRE-ADMISSION PLAN

About three years ago, at Pennsylvania Hospital in Philadelphia, we instituted a system whereby all elective cases must be registered and interviewed before admission. This system is based on a plan of classifying patients as to urgency of admission and works as follows:

Patients are assigned to one of three admission-priority groups so that the interviewer can arrange a suitable appointment date without endangering the patient's health. Priority 1 are emergency cases where the admission cannot be postponed beyond the original date. Priority 2 are cases requiring bed care, but whose admission can be delayed for as long as three weeks. Priority 3 are cases also needing bed care, but whose admission may be postponed indefinitely. Each patient is classified by the examining physician and the attending nurse or clerk is responsible for recording the information.

This system covers all patients regardless of from where they are referred. Outpatient department referrals, for example, are processed in the following manner: After the examining physician has decided that the individual must be hospitalized for treatment, he requests the attending clerk to make the necessary arrangements. The clerk obtains the diagnosis, urgency classification, tentative admission date and any additional information needed.

By conducting credit procedures as business firms do whereby all elective cases must be registered and interviewed before admission, Pennsylvania Hospital has realized additional income.

This information is recorded on a standard referral slip which is then given to the patient for identification upon admission. The clerk also prepares a medical history face sheet showing the person's classification, name, address and other pertinent facts, plus an itemized record of all recent tests or treatments. This face sheet becomes the first page of the patient's case history together with the list of services given him. The service list is kept to prevent needless duplication of expensive tests.

After he completes the forms, the patient is interviewed by the credit department. All essential information including employment, all sources of income and expenses are recorded on a credit application. Careful consideration is then given to the patient's type of illness and treatment as well as to his probable length of stay, and the rates and charges are decided in accordance with his income and expenses.

Each full-pay patient is told that upon admission he must pay the estimated bill in full. Part-pay patients are advised to pay an amount estimated to cover the reduced bill in full. If there is any reason why this cannot be done, arrangements are made to accept partial payment in advance. Before admission in every case, however, a suitable plan is agreed upon to ensure full payment of the balance due.

Admission dates finally are determined by the amount of time the patient needs to obtain the amount agreed upon and by his urgency rating. Anyone who fails to bring the amount specified when reporting for admission, is re-interviewed to determine the reasons for his failure. The case is then settled on the basis of his reclassification.

Priority 1 cases are admitted at once, irrespective of their preparedness to pay. The admission of those classified as Priority 3 usually is postponed until the patient is able to make the required payment. In Priority 2 cases, however, the examining doctor or chief resident physician is consulted to determine whether or not admission can be delayed further.

At Pennsylvania Hospital, all ward patients including accident cases, referrals by staff or other doctors and those who simply apply for treatment, are officially admitted to the hospital through the emergency department. Pre-admission registration of these cases is effected through the procedures just described.

Emergency cases, of course, are admitted without delay and the financial interview is postponed until the patient's condition has improved or contact has been made with a responsible person. Elective cases are referred either to the outpatient department for preliminary treatment and ultimate pre-admission registration, or directly to the credit department for an interview. The credit department will establish an admission date based upon the patient's classification and ability to raise the necessary advance payment.

To successfully use this same plan for private patients requires full cooperation of staff doctors. When a physician desires to admit a patient he merely calls the hospital (or has his secretary do so) to make an appointment for an interview and to give the diagnosis, urgency classification or date by which the patient should be admitted, the probable length of stay, and the type and number of anticipated auxiliary tests.

When the private patient or party responsible is interviewed, he is shown the various rates for each type of accommodation and service so he can make his own selection. Arrangements then are made for advance payment either in full or in part, according to the judgment of the interviewer and the patient's admission date.

From the hospital's standpoint, the advantages of pre-admission registration are numerous. It not only enforces advance payment, but allows for an investigation of doubtful information, insurance coverage, credit standings and other pertinent factors.

The pre-registration plan also offers many advantages to patients. Foremost is the fact that interviews are conducted at a time when patients are not faced with the anxiety and fear of immediate hospitalization. This leads to a more rational discussion of charges and a better understanding between individuals and the hospital. Second, by having advance knowledge of approximate costs, patients can make the necessary budget arrangements and enter the hospital with a minimum of worry about the necessity of meeting bills larger than can be paid. Finally, time required for actual future admission is shortened because essential forms have been completed in advance.

CHIEF ADVANTAGE

But the most important advantage of this plan is the fact that the hospital is able to investigate any doubtful information prior to the patient's admission. This can be done through the local credit bureau or by hospital personnel. At Pennsylvania Hospital, we do our own checking and our admitting officers are trained to make every effort to authenticate the facts during the interview in order to curtail later investigative expenses. Because there are some patients who do not hesitate to understate their income and overstate their expenses in order to obtain preferred rates, interviewers must utilize considerable tact, common sense and judgment in analyzing the information presented during the interview. The purpose of this careful screening and investigating is not to refuse treatment, but to protect the hospital from being imposed upon.

A good example of the need for investigation occurred at Pennsylvania Hospital two years ago. A man about 70 years old was interviewed on the date of his wife's emergency admission to the hospital. He said that he averaged

about $15 a week in salary and that he and his wife paid $20 a month for rent. These figures normally would indicate inability to pay.

The admitting officer who was rating the case, however, was alerted by the man's offer to pay $7 a week, though he had previously said he had no savings and was forced to live very frugally. By piecing together the information obtained from neighbors, it was possible to estimate the couple's total bank deposits as approximately $35,000. The banking officials verified this estimate. Consequently, the patient was rated full-pay and the hospital collected a bill in excess of $2,000.

There is still another plan in use throughout the country. This one, also designed to enforce advance payment, involves mailing a reservation notice together with a credit pamphlet to the patient as soon as the doctor contacts the hospital. The reservation notice indicates the kind of room that has been reserved and the credit pamphlet contains various facts about the hospital, including a detailed explanation of what must be done to gain admission.

No pre-admission payment plan is complete, however, without suitable procedures for handling emergency admissions. The majority of these cases, whether private or ward, represent a real problem since the need for hospitalization is usually unexpected. Promptness of action is the keynote here.

As soon as the admission notice has been received, the hospital should find out if the patient was accompanied by anyone. If so, that person should be consulted before he leaves the hospital, about a financial arrangement for the patient. Otherwise, preparations should be made to conduct the financial interview with the patient as soon as he is able.

These interviews with the patient, however, must be conducted with considerable tact and diplomacy, for the individual usually is distraught with fear and anxiety. If it is impossible to interview any one at the time of admission, the admitting officer should contact the patient's family by telephone, by sending a bill or by arranging to have the patient's first visitors sent to the business office.

Liability or accident cases are the most difficult of all emergency admissions to handle. Accident victims always feel that the other fellow was at fault and that he should pay the bill. Naturally, the hospital has no claim against third parties and every effort must be made to collect from the patient. If this is not possible, every attempt should be made to determine the names and addresses of those involved in the accident and the identity of any insurance companies involved. If there is an insurance company, the patient should be required to sign an assignment form authorizing the company to make direct payment to the hospital at the time of settlement. This form, together with a request for acknowledgment, should be sent to the company as soon as it is completed.

OTHER LEGAL ASPECTS

If the patient engages the services of an attorney, there usually is a request for a medical history report. In cases where the bill is small, the hospital should insist upon full payment before releasing this information. But if the bill is large and it is evident that the patient cannot pay, the hospital should insist upon a letter from the attorney guaranteeing payment out of any monies he is able to procure for the patient. This letter must be countersigned by the patient or accompanied by the patient's assignment authorizing the attorney to pay the hospital bill out of the proceeds of the settlement. Without this authorization, the attorney can evade payment by stating that his client refused to permit direct payment of the hospital bill.

Accident cases cannot be successfully handled without the cooperation of insurance companies or self-insured organizations. For this reason, hospital officials should make it a point to call personally upon the claim managers of the large insurance companies. These personal calls help in developing the friendship and cooperation of the insurance executive and increase the hospital's chance of collecting.

If the emergency admission is a compensation case, the important thing is to establish liability. This should be done by an immediate telephone call to the employer, at the same time obtaining from him, for follow-up purposes, the name of the insurance company.

Our policy at Pennsylvania Hospital is not to accept an assignment of benefit in lieu of direct payment from private patients. The insurance factor, however, is one of the most important points to consider when determining the charge for ward patients, providing full information about the amount of insurance benefit available.

It is desirable, of course, to collect payment for charges directly from all patients. But many individuals, primarily ward patients, are unable to do this and the hospital is compelled either to accept assignments or to state flatly that it does not recognize this particular type of insurance coverage. In my opinion, it is more advantageous to accept assignments under such cases than to rely on the patient after he has collected his claim from the insurance company. If the claim is rejected, the hospital still has the opportunity to collect from the patient, as would have been necessary anyway if the insurance coverage was not recognized. Here again the hospital can add a personal touch by making a personal call to the various managers of the most active insurance companies to explain the hospital's position.

During the three years in which the various procedures described above have been in effect at Pennsylvania Hospital, hundreds of patients have paid their bills in full at admission time largely due to the pre-registration procedure. Thousands of others have made substantial down payments on admission, while many others have paid as little as $5, representing the first of a series of installments on the complete charge.

Our experience in conducting credit procedures as business firms do, has realized considerable additional income from those able to pay. And this, in turn, has resulted in many additional days of free bed care for those who are unable to pay, as well as funds for the research and teaching facilities of our medical staff.

Self-appraisal of hospital procedures by physicians and administrators is the basis for a new Association study in which any hospital may participate.

SELF STUDY: Medico-administrative reviews are cutting patient costs

THE HOSPITAL administrator finds himself today very much like a man whose family does not understand why living costs are so much higher now than they were 15 years ago. He is asked frequently why costs have taken such an unbelievable rise and how much his hospital is doing to keep the patient's bill equitable.

Fortunately, the complex cost problem and the job of explaining it are not new to most administrators. They represent an endless challenge in administration and to a degree reflect the administrator's effectiveness as a coordinator of hospital service. But in this period of inflation—and at a time when progress in medicine is having a great impact on costs—it is even more difficult to justify a service which people do not ordinarily want and would prefer not to need.

For most administrators this justification is not the same as a defensive attitude about costs because they have done much in recent years to hold down excessive increases. And, creditably, they have enlisted the help of everyone in the hospital in doing so. Likewise, and because his work so directly influences the patient's bill, the physician has been called upon to reduce every possible waste, material and procedural.

A NEW STUDY

Late in 1951, the Council on Professional Practice of the American Hospital Association began a study to assist administrators and medical staff members to cooperate in reducing the patient's hospital costs by reviewing, step-by-step, many of the routines that go into hospitalization. This evaluation, conducted according to the individual needs and preferences of each hospital, rests on two basic but profound questions: Exactly what are we attempting to do? How practical is our attempt?

Sixty general hospitals in the United States and Canada now are participating in a pilot study conducted by the council and the response of physicians and administrators shows that many more now will wish to begin this voluntary form of self-appraisal. Whether, as a result of the appraisal, the staff and administrator agree to place a three-day limit on orders for expensive medications or special diets, or perhaps decide that from now on operating room charges should be based on time rather than itemized estimates of expense, the aim of the study remains the same—to reduce costs to the patient while maintaining the highest standards of care.

Proof that such a study is really wanted comes from the many administrators and medical staff members who are convinced professional-administrative cooperation can uncover needless, time-consuming procedures. The idea that professional, administrative and departmental group action are necessary has been the basis for many projects. But this study affords an unusual opportunity for physician participation in management activities of the hospital. In instances already reported, medical staff recommendations have substantially reduced length of stay or have suggested new, untried procedures to cut costs.

The need for the study is self-evident. In spite of the many organizations actively trying to reduce costs, and a cost-consciousness that is growing in the hospital field, the Council on Professional Practice has found that the criticisms of hospitalization costs are not always unfounded. An editorial in the Journal of the Michigan State Medical Society for July 1951 revealed, for example, that there were approximately 1,700 "inexcusably used" hospital days in one large hospital in a single month. In another hospital, it was discovered that faulty administrative procedure in handling the scheduling of surgical operations was adding one hospital day to the stay of every surgical patient in that hospital. Members of the council are convinced that such instances of waste are due not to blundering or neglect but to a lack of self cross-examination between professional and administrative departments.

EVALUATION GUIDES

Cumulative statistics, however, are not the object of the council's study in self-analysis. This project is a matter of individual hospital action, with all sections of the hospital which contribute directly to patient care participating.

To assist each cooperating hospital in beginning its study, the council has prepared a preliminary outline, made up of questions leading to procedural evaluation. Intended only as a guide, the outline suggests such questions as:

Have you examined your admission procedure?

Can some admitting procedures be done prior to the arrival of the patient at the admitting office?

Are x-ray, laboratory and other ancillary services readily available at all times?

Are all transfers of patients from service to service routed through the admitting office?

Are there administrative checks on the length of time each patient has been in the hospital?

Have you reviewed your standing and routine orders recently?

Is your entire staff familiar with standing and routine orders?

With each of these questions, guiding comments are made for the administrator or the hospital committee organized to conduct the study. For example, in relation to the question "*Does your admitting office arrange immediate appointments for routine diagnostic tests on admission of the patient?*" the following comments were added:

"Some hospitals have found this procedure to be a time-saver in length of stay.

"A. Ancillary services such as x-ray and laboratory must work according to strict time schedules and bookings in large hospitals. Appointments made by the admitting office save the time of the nurse on the floor and enable her to synchronize floor care with ancillary service appointments. Some institutions have found that in addition to the saving in nursing hours, such a procedure eliminates time wasted by patients waiting in bed for appointments.

"B. Walking patients may be routed to the x-ray and laboratory for routine tests and appointments before they go to the nursing unit.

"C. In the case of private patients referred for admission, some hospitals have followed the practice of requesting the attending physician to requisition the tests which he desires. The patient presents the requisition at the admitting office and the tests are expedited with a minimum of patient waiting."

EARLY REPORTS

In the first days of their study most of the participating hospitals presented the project at a full medical staff meeting. After a review of the council's outline, a committee was usually appointed made up of physicians, representatives from the various clinical departments of the hospital, department heads, heads of the nursing service and administrative officers. Some of the larger hospitals appointed subsidiary departmental committees.

These committees met at regular intervals, reported on findings and submitted recommendations. They produced many ideas and encouraged an exchange of problems that will bring interdepartmental efficiency to many hospitals. In an Eastern hospital, for example, the director of nursing and the central supply room supervisor discussed thoroughly the various aspects of each nursing tray as it had been set up routinely for many years. Sample trays with suggested improvements were then prepared for consideration by the nursing faculty, and five to eight trays were analyzed at each meeting. Before the trays were set up in final form, the administrator, the director of nursing and the central supply supervisor met with the surgical technique committee to present medical considerations such as length, bore and types of needles to be used for various procedures, the purchase of a water or mercury monometer and the sizes and types of materials for dressings.

Trial trays, incorporating the suggestions offered, were then put to use. Doctors, general duty nurses and students were encouraged to make suggestions for improving the trial trays. In time, as trays became approved, standardization of supplies and equipment was accomplished and a perpetual inventory program was set up for the nursing department.

In most of the hospitals participating in the council's study, such changes and recommendations, after being approved by the executive committee of the full staff or the staff itself, were presented by the administrator to the board of directors for consideration.

All participating hospitals were asked to report on progress being made after two months and to indicate any serious difficulties they had had. Each of the hospitals was enthusiastic in admitting the need for changes in the interest of more economical care of the patient. One staff member wrote, "The main ad- to the medical staff the importance vantage as I see it is to emphasize of the team, and this study is a classical example of how effective that approach proves to be."

And an administrator commented, "The greatest value of this (medico-administrative) committee comes about with the self-examination that is necessary to bring out some of our weak points, and it makes everybody more alert to the necessity of proper and prompt communications between the various hospital departments. It is suggested that a similar study be conducted within a period of six months to determine whether or not the policies recommended by this committee are being carried out effectively."

EXPECTED RESULTS

After so short a time, evaluations of procedural changes have not yet been made, but recommendations already point to savings of patient days and personnel time. As the study progresses and preliminary reports are received, effective ideas will be exchanged by hospitals and the council hopes for a new and lasting awareness of medical staff participation in cutting down the patient's hospital bill.

In recommending its study, the Council on Professional Practice recognizes that it is taking but one approach to the cost problem. Other groups including committees and commissions are investigating various factors of hospital costs, but these are not necessarily related to the internal functioning of the individual hospital. The council's effort is aimed at evaluating procedures within the hospital that may be improved through the cooperation of those who contribute to patient welfare.

The first objective is a desire for action. The second is developing an attitude or state of mind for cooperative and continuing appraisal of how hospital activity reflects on cost to the patient.

All hospitals are encouraged to participate and contribute to the council's study. They can do so by first writing to Dr. Dallas Sutton, Washington Service Bureau of the American Hospital Association, 1756 K Street, N.W., Washington 6, D. C., to request a copy of the council's suggested questions and procedures.

EDITORIALS

Aim of the American Hospital Association: To promote the public welfare through the development of better hospital care for all the people.

The Elements

SINCE THEY WERE FIRST published in 1946, the "Elements of the General Hospital" have had a marked effect upon the quality of planning that has gone into America's postwar hospital construction.

HOSPITALS first presented the "Elements of the General Hospital" to the field in its May 1946 issue. Recognizing that hospital design is not static, the Public Health Service, in cooperation with interested organizations, has carried on a program of constant study since that time, resulting in additions to the original elements and revisions of some of the earlier versions.

Beginning on page 79 of this issue, the journal presents the "Elements" as they now exist, complete with all additions and changes made since their 1946 debut. Anyone who is planning or building a hospital will find these elements a necessity. Anyone who is considering a building program in the future will do well to study them in advance. Anyone who is interested in better layout for better administration will find it worth his while to review the elements for the ideas they present.

Physicians do control costs

AN EDITORIAL IN THE February 20 issue of the *Journal of New York Medicine* philosophizes about the increase in all prices, including hospital charges and physicians' fees. This editorial quotes the Bureau of Medical Economic Research of the American Medical Association, which shows that, whereas in 1930 the physician received 32 cents of the medical care dollar, today he receives only 28 cents. Hospitals received 14 cents of the medical care dollar in 1930, while in 1950 hospitals received 23 cents. The proportion of the medical care dollar going to dentists has decreased from 16 to 12 cents in the same period.

An interesting aspect of the editorial is the following, which is a direct quote: "The physician has no control over costs, naturally."

While this editorial was not primarily concerned with the relationships of physicians to hospital costs, this conclusion is so startling and yet so typical of the first reaction of many physicians that it is worthy of mention, particularly so since it is an editorial in a journal going to members of the largest state medical society in the country.

As a practical matter, physicians do control hospital costs. They set the basic requirements for the patient's care, which determines the amount of equipment and personnel which the hospital requires. They establish this not only on the basis of the standard of care which they urge the hospital to adopt but, equally fundamental, on the basis of the tests which they order or do not order for their patients. Further and even more fundamental, the number of times the patient is admitted to the hospital and the length of his stay in the hospital are completely controlled by the physician.

It is time that hospitals exerted more effort in bringing to physicians an understanding of their very great responsibility for hospital costs. This should be a matter of major concern to the Commission on Financing of Hospital Care. Also, more hospitals should set up joint working committees between their medical staffs and administration to study the relationship of the physician to hospital costs and to adopt cooperative projects which can keep those costs at the lowest level consistent with good hospital care.

The Association's pilot study of hospital costs, recommended by the Council on Professional Practice, is available to any hospital interested in developing such cooperative programs, and many already are participating, successfully, in medico-administrative studies of their own. (See Self-Study: Medico-Administrative Reviews are Cutting Patient Costs on page 75 of this issue.)

Philanthropy as an investment

SINCE THOUGHTS ABOUT federal taxes should still be fresh in the minds of individuals and corporations, it seems appropriate to take more than casual notice of how Internal Revenue laws encourage corporate giving to tax-exempt "educational, scientific and welfare" agencies. An understanding of this tax philosophy of government now may pay eligible hospitals dividends in the months ahead.

The present tax laws specifically enable business organizations to effect tax savings by making contributions to educational, scientific and welfare organizations. The Internal Revenue Act permits corporations to donate five per cent of their net income to such tax-exempt agencies as nonprofit hospitals. While there is presently no available information as to how many hospitals were successful in interesting corporations to make contributions under this tax provision, it is known that in only one year did the total contributions to educational, scientific and welfare organizations exceed one per cent. This would indicate that

agencies eligible to receive corporate gifts have not done an effective job in selling themselves to business.

With the almost continuous need by hospitals for funds for operational demands as well as for construction and capital expenditures, the Revenue Act provides an important and practically unexploited source of financial aid.

But to tap this source requires more than just a routine solicitation. As pointed out in the article on page 67, "the frank approach to business sells tax deduction but shuns the weak argument of community responsibility and good-will return only." Industry is interested in taking advantage of tax deduction opportunities, and a variety of tax-exempt agencies are competing very actively for such funds. Hospitals offer industry a particularly unique area for the investment of tax dollars. Contributions to hospitals can not only help bring community good will to the corporation but can result in potential income to it as well. It may be termed "hard-headed business," but the fact remains that hospitals must approach realistically the problem of how best to compete for corporate gifts. An effective approach must be in terms both of what the contribution will do for the hospital and what it will do for the giver. In this sense philanthropy by the contributor also becomes an investment. Under the provisions of the Internal Revenue Act, hospitals will do well to review their needs in relation to how industry can underwrite their needs, and in so doing they will be making a worthwhile investment for industry.

New intern matching plan tested

ON MARCH 14 the results of the first actual test of the Intern Matching Plan were tabulated by the National Interassociation Committee on Internships. Official details about these results will be reported in a forthcoming issue of HOSPITALS. At this time, however, two particularly interesting aspects are worth recording.

One is the fact that 94 per cent of the interns received their first or second choice, 84 per cent having received their number one choices. Second, in spite of the fact that a total of 10,414 internships of all types were offered by hospitals with only 5,681 interns eligible to fill the demand, well over half of the hospitals seeking interns either completely or partially received their complement.

For those hospitals receiving no interns or not filling completely their complement, it seems apparent that the students had one or both of the following opinions:

(1) The type of internship offered; or (2) the educational opportunities the individual hospital offered.

While a complete analysis of the Intern Matching Plan must of necessity await further study, even at this early date one definite conclusion is obvious—it is humanly impossible for 5,681 interns to fill 10,414 internships regardless of what type of plan is devised.

Accreditation director

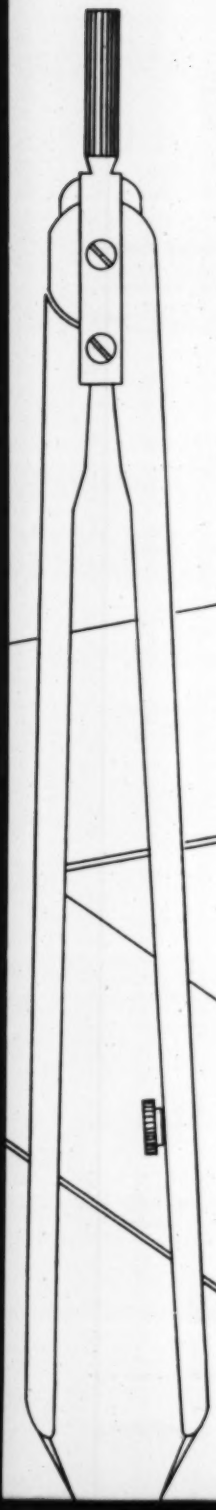
ANNOUNCEMENT OF THE appointment of Dr. Edwin L. Crosby as director of the Joint Commission on Hospital Accreditation should be received reassuringly on all sides. As a physician, an administrator and as a leader on many fronts of the health field, he brings to the commission the right temperament and experience so vitally needed to get the new hospital accreditation program off to a sound and auspicious beginning.

Indicative of the regard with which all groups affiliated in this new program hold Dr. Crosby is the report that his was the only name presented to the commission and that his appointment was by unanimous vote. By this action, there is positive proof that the five organizations supporting the commission are most sincere in their desire to develop the best possible type of accreditation program and that there is every intention to make it succeed.

As the new commission's work begins, the American College of Surgeons can feel a deep sense of satisfaction and accomplishment resulting from its 34 years in the field of hospital standardization. Dr. Malcolm T. MacEachern, who was so instrumental in guiding the college program over the years, has highlighted, in this issue, the origination and some of the achievements of that program. It would take a volume to portray fully the progress of the A.C.S. program from the first inspections in 1918, when 89 of 692 hospitals met the then minimum standards, to 1950, when 82 per cent of the 4,021 hospitals surveyed were approved.

The impact of hospital standardization on hospitals and the health field cannot in any way be minimized. The inauguration of the new commission will broaden and further develop the objectives sought by the A.C.S.

It is in the light of this goal that all affiliated with the program must work together wholeheartedly. To date two major steps give evidence that such is the case: First, the fact that the five organizations concerned established cooperatively the Joint Commission on the Accreditation of Hospitals; and second, the appointment of Dr. Crosby as commission director. The next move now is up to the constitutent organizations to give him the complete support required to do the job expected. Hospitals, the professions and the public will watch this and succeeding moves with more than casual interest.



Elements of the GENERAL HOSPITAL

REVISED EDITION

FEDERAL SECURITY AGENCY
Public Health Service
Division of Hospital Facilities

HOSPITALS, Journal of the American Hospital Association, April 1952

LIST OF DETAIL DRAWINGS

NOTE: Plan number followed by letter "R" indicates a revision of the existing plan, as published in the original "Elements of the General Hospital." A decimal number indicates a new plan.

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These plans were prepared by the Division of Hospital Facilities, under the general direction of John W. Cronin, medical director, in cooperation with the Division of Medical and Hospital Resources, John R. McGibony, medical director.

ELEMENTS of the general hospital

—Revised edition

GEORGE BUGBEE
Executive Director
American Hospital Association

IN THE ENTIRE FIELD of architecture there is probably no design problem more challenging than that presented by the hospital. Anyone who has ever worked inside a hospital knows the marked effect that the physical plant can have upon the hospital's success in its important mission of reducing pain, restoring health and prolonging life. Moreover, the design of the physical plant has a direct bearing upon the cost and ease of operating and maintaining such a complex institution as a hospital.

Although all hospitals have a basic similarity in the functions to be housed, there can be no standardization of design. At best, each hospital presents major differences, individual local problems that must be solved for that one hospital if it is to reach its potential usefulness.

Yet, because there is a basic similarity, it is possible to suggest certain elements that must be considered in planning any hospital. The "Elements of the General Hospital" are intended to do just that. They provide guides that can be readily adapted to a local situation—in a form that is understandable to anyone concerned with hospital planning.

The original "Elements of the General Hospital" were presented to the field in HOSPITALS for May 1946 and *Architectural Record* for June 1946. Since that time they have been used extensively as planning guides during the greatest hospital construction period in history.

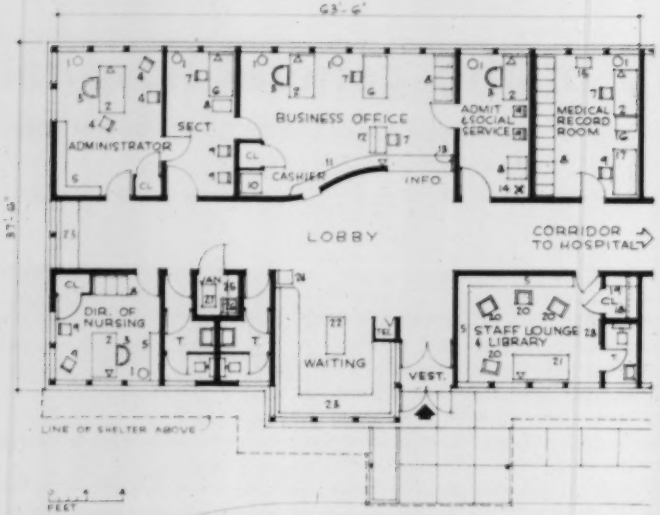
But the Elements are not static. They have been revised and improved through the years, always reflecting the newest thinking and the latest advances in medical and hospital procedures. They are a synthesis of the best judgment of those who manage the internal functions of the hospital and those who plan the physical plant to facilitate those functions.

The "Elements of the General Hospital" that appear in these pages represent the last word in this pooling of ideas and experience. They have been brought completely up to date and include all additions and revisions that have been made since they first appeared in 1946.

These elements represent the work of many organizations and individuals. But in the final analysis the credit goes, without question, to the Public Health Service of the Federal Security Agency. The Public Health Service, through its Division of Hospital Facilities, has contributed immeasurably to the improvement of hospital design in the United States and indirectly throughout the world. The Public Health Service, the surgeons general who have supported this work, and the skilled individuals who thought out and worked out the complex details deserve much credit for the improvements in hospital design which they have made.

Certainly the "Elements of the General Hospital" are an excellent example of cooperative activity between the Public Health Service and the hospital field. They have made and will continue to make a significant contribution to the improvement of hospital design and, through better planning, to the improvement of patient care in this country and throughout the world.

ADMINISTRATION DEPARTMENT

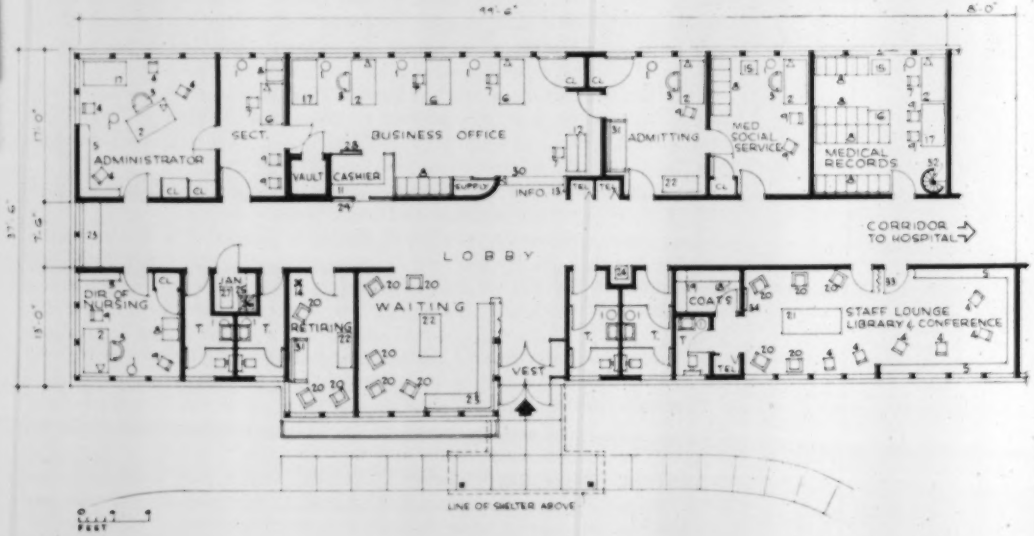


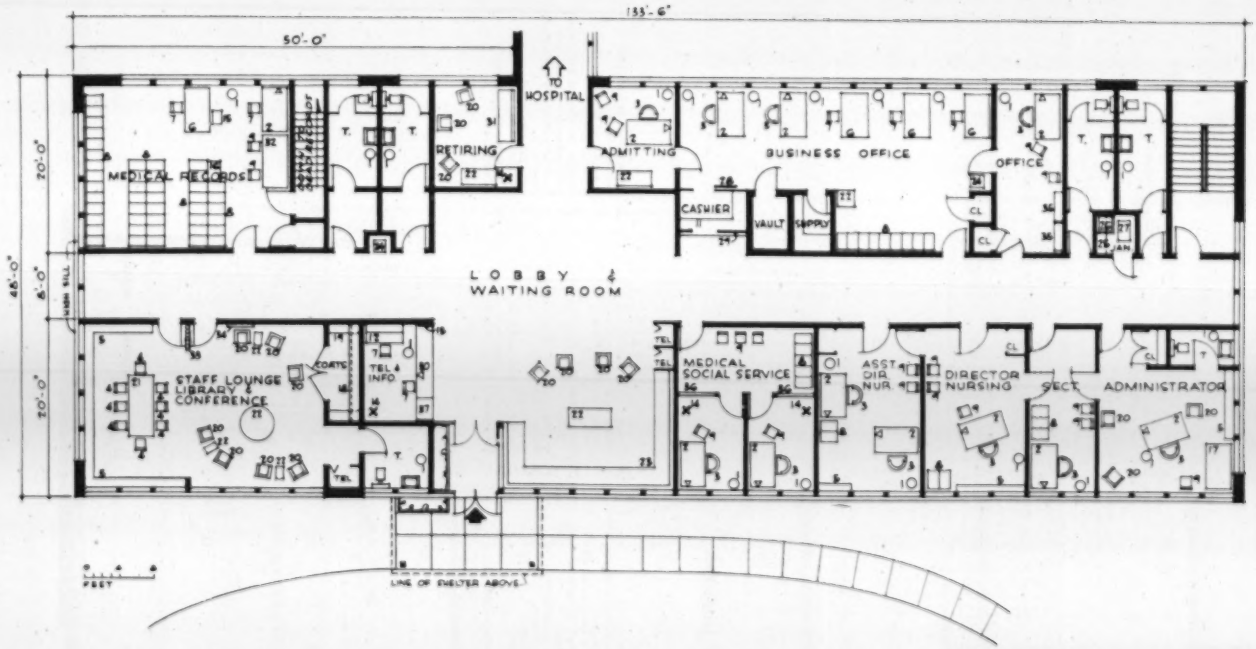
1. Waste paper receptacle
2. Executive-type desk
3. Executive-type chair
4. Straight chair, upholstered
5. Built-in bookshelves
6. Typist's desk
7. Typist's chair
8. Filing cabinet
9. Straight chair
10. Safe
11. Counter, 40 inches high, cash drawer, with cabinets and drawers below
12. Telephone switchboard
13. Doctors' in-and-out register
14. Costumer
15. Typewriter table
16. Card index file
17. Table, 34 x 60 inches
18. Hat shelf with clothes rod below
19. Shelf, 2 feet above floor
20. Easy chair
21. Conference table
22. Table
23. Built-in bench
24. Water cooler
25. Shelf
26. Janitor's service sink
27. Mop truck
28. Bulletin board, 26 x 24 inches

1—Administration Suite for a 50-Bed General Hospital

2—Administration Suite for a 100-Bed General Hospital

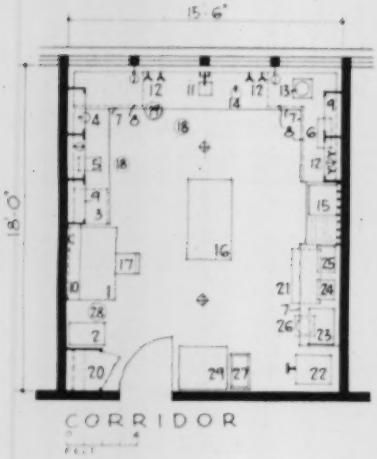
1. Waste paper receptacle
2. Executive-type desk
3. Executive-type chair
4. Straight chair, upholstered
5. Built-in bookshelves
6. Typist's desk
7. Typist's chair
8. Filing cabinet
9. Straight chair
11. Counter, 40 inches high, cash drawer, with cabinets and drawers below
12. Telephone switchboard
13. Doctors' in-and-out register
14. Costumer
15. Typewriter table
16. Card index file
17. Table, 34 x 60 inches
18. Hat shelf with clothes rod below
19. Shelf, 2 feet above floor
20. Easy chair
21. Conference table
22. Table
23. Built-in bench
24. Water cooler
25. Shelf
26. Janitor's service sink
27. Mop truck
28. Wire mesh partition with sliding gate
29. Glass screen
30. Counter, 48 inches high, open below
31. Three passenger settee
32. Spiral stairway down to dead record room
33. Collapsible partition
34. Bulletin board, 26 x 24 inches





3—Administration Suite for a 200-Bed General Hospital

1. Waste paper receptacle
2. Executive-type desk
3. Executive-type chair
4. Straight chair, upholstered
5. Built-in bookshelves
6. Typist's desk
7. Typist's chair
8. Filing cabinet
9. Straight chair
11. Counter, 40 inches high, cash drawer, with cabinets and drawers below
12. Telephone switchboard
13. Doctors' in-and-out register
14. Costumer
15. Typewriter table
16. Card index file
17. Table, 34 x 60 inches
18. Hat shelf with clothes rod below
19. Shelf, 2 feet above floor
20. Easy chair
21. Conference table
22. Table
23. Built-in bench
24. Water cooler
26. Shelf
26. Janitor's service sink
27. Mop truck
28. Wire mesh partition with sliding gate
29. Glass screen
30. Counter, 48 inches high, open below
31. Three passenger settee
32. Table, 34 x 72 inches
33. Collapsible partition
34. Bulletin board, 26 x 24 inches
35. Bookcase
36. Translucent glazing
37. Counter, lift top and gate front

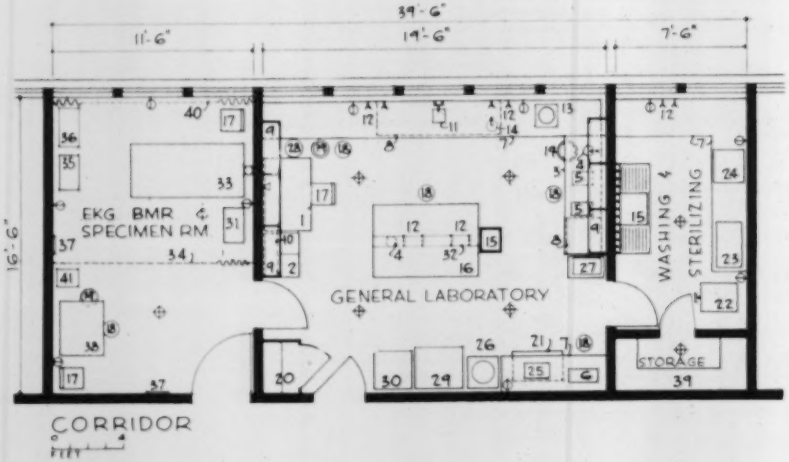


4—Laboratory for a 50-Bed General Hospital

1. Desk
2. Filing cabinet
3. Microscope table, 30 inches high, with cabinets and slide drawers below
4. Cup sink with gooseneck spout
5. Microscope
6. Analytical balance with weights
7. Acid resisting counter, 36 inches high
8. Cabinets below counter
9. Wall cabinets
10. Book shelves
11. Acid resisting laboratory sink with gooseneck spout
12. Air, gas and electric outlets
13. Single element hot plate
14. Bunsen burner
15. Acid resisting laboratory sink with peg boards
16. Table, 30 x 54 inches
17. Straight chair
18. Stool
19. Sanitary waste receptacle
20. Closet
21. Wheel cart for frozen sections
22. Laboratory autoclave, 17½ x 26 inches
23. Hot air sterilizer, 18 x 14 x 14 inches
24. Incubator, 13 x 14 x 13 inches
25. Water bath
26. Centrifuge
27. Shaking machine on stand
28. Waste paper receptacle
29. Refrigerator, 8 cubic feet

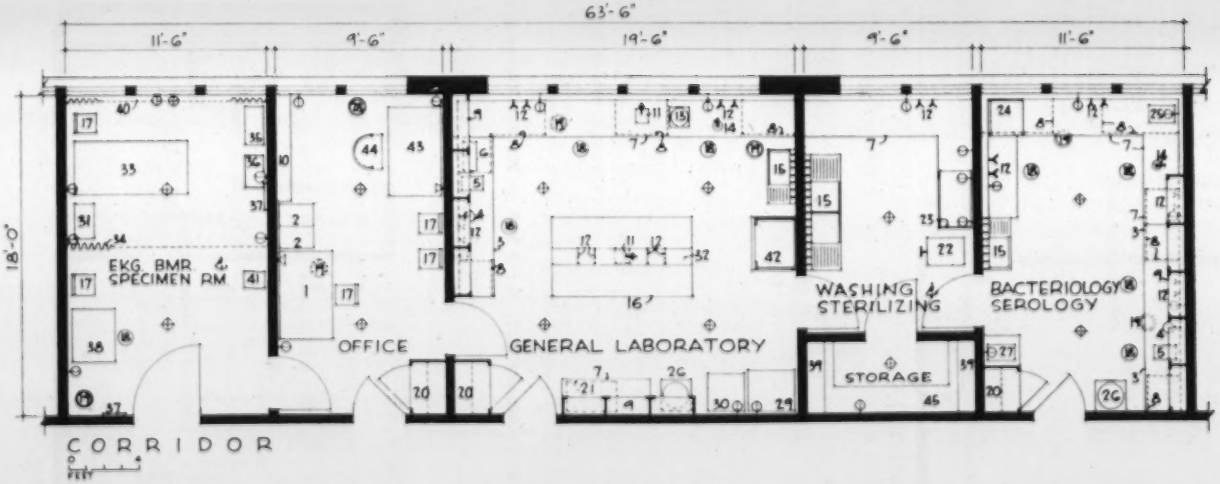
5—Laboratory for a 100-Bed General Hospital

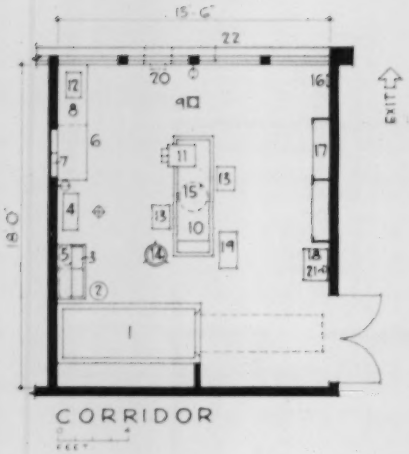
1. Desk
2. Filing cabinet
3. Microscope table, 30 inches high, with cabinets and slide drawers below
4. Cup sink with gooseneck spout
5. Microscope
6. Analytical balance with weights
7. Acid resisting counter, 36 inches high
8. Cabinets below counter
9. Wall cabinets
10. Book shelves
11. Acid resisting laboratory sink with gooseneck spout
12. Air, gas and electric outlets
13. Single element hot plate
14. Bunsen burner
15. Acid resisting laboratory sink with peg boards
16. Chemistry table
17. Straight chair
18. Stool
19. Sanitary waste receptacle
20. Closet
21. Wheel cart for frozen sections
22. Laboratory autoclave, 17½ x 26 inches
23. Hot air sterilizer, 24 x 14 x 14 inches
24. Incubator, 18 x 18 x 27 inches
25. Water bath
26. Centrifuge
27. Shaking machine on stand
28. Waste paper receptacle
29. Refrigerator, 8 cubic feet
30. Refrigerator, 6 cubic feet
31. Bedside table
32. Shelves over chemistry table
33. Hospital bed
34. Cubicle curtain rod and curtain
35. Basal metabolism apparatus
36. Electrocardiograph apparatus
37. Hook strip
38. Table, 24 x 36 inches
39. Shelving
40. Sliding window curtain
41. Adult scale



6—Laboratory for a 200-Bed General Hospital

1. Desk
2. Filing cabinet
3. Microscope table, 30 inches high, with cabinets and slide drawers below
4. Cup sink with gooseneck spout
5. Microscope
6. Analytical balance with weights
7. Acid resisting counter, 36 inches high
8. Cabinets below counter
9. Wall cabinets
10. Book shelves
11. Acid resisting laboratory sink with gooseneck spout
12. Air, gas and electric outlets
13. Single element hot plate
14. Bunsen burner
15. Acid resisting laboratory sink with peg boards
16. Chemistry table
17. Straight chair
18. Stool
19. Sanitary waste receptacle
20. Closet
21. Wheel cart for frozen sections
22. Laboratory autoclave, 17½ x 26 inches
23. Hot air sterilizer, 30 x 24 x 18 inches
24. Incubator, 25 x 18 x 27 inches
25. Water bath
26. Centrifuge
27. Shaking machine on stand
28. Waste paper receptacle
29. Refrigerator, 8 cubic feet
30. Refrigerator, 6 cubic feet
31. Bedside table
32. Shelves over chemistry table
33. Hospital bed
34. Cubicle curtain rod and curtain
35. Basal metabolism apparatus
36. Electrocardiograph apparatus
37. Hook strip
38. Table, 30 x 36 inches
39. Shelving
40. Sliding window curtain
41. Adult scale
42. Fume hood
43. Executive-type desk
44. Executive-type chair
45. Counter, 36 inches high, cabinets below

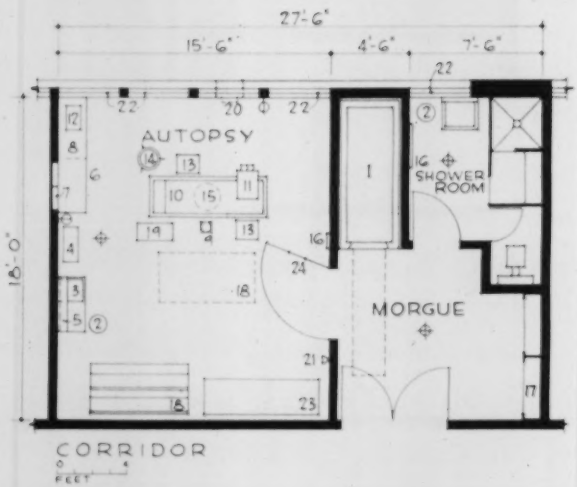




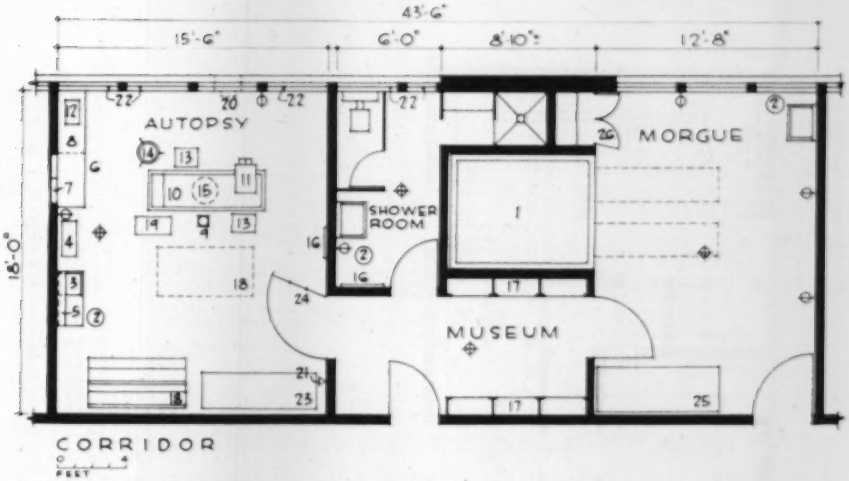
7—Morgue and Autopsy Room for a 50-Bed General Hospital

1. Mortuary refrigerator for 2 bodies
2. Waste paper receptacle
3. Combination instrument and scrub sink with gooseneck spout and spray and knee control
4. Instrument sterilizer, 9 x 10 x 20 inches, on stand
5. Shelf over sink
6. Cabinet below counter
7. Double recessed view box
8. Counter, 36 inches high, open below
9. Floor drain
10. Autopsy table with sink
11. Mayo table
12. Scales
13. Footstool
14. Kick bucket
15. Light
16. Hook strip
17. Specimen cabinet with glazed doors
18. Metal top table, 16 x 20 inches
19. Suction apparatus
20. Ventilating fan
21. Telephone outlet
22. Obscure glass

8—Morgue and Autopsy Suite for a 100 or 200-Bed General Hospital



1. Mortuary refrigerator; for 100 bed hospital, 2 bodies; for 200 bed hospital, not less than 3 bodies
2. Waste paper receptacle
3. Combination instrument and scrub sink with gooseneck spout and spray and knee control
4. Instrument sterilizer, 9 x 10 x 20 inches, on stand
5. Shelf over sink
6. Cabinet below counter
7. Double recessed view box
8. Counter, 36 inches high, open below
9. Floor drain
10. Autopsy table with sink
11. Mayo table
12. Scales
13. Footstool
14. Kick bucket
15. Light
16. Hook strip
17. Specimen cabinet with glazed doors
18. Portable observation stand
19. Suction apparatus
20. Ventilating fan
21. Telephone outlet
22. Obscure glass
23. Stretcher
24. View panel



9—*Morgue and Autopsy Suite for a 200-Bed General Hospital*

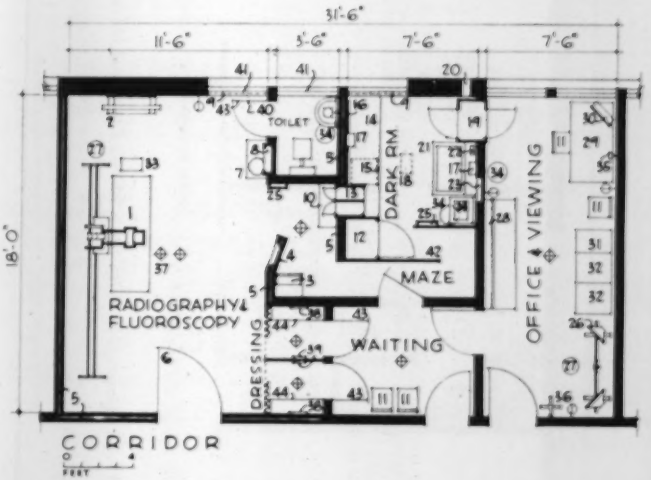
1. Mortuary refrigerator for 4 bodies
2. Waste paper receptacle
3. Combination instrument and scrub sink with gooseneck spout and spray and knee control
4. Instrument sterilizer, 9 x 10 x 20 inches, on stand
5. Shelf over sink
6. Cabinet below counter
7. Double recessed view box
8. Counter, 36 inches high, open below
9. Floor drain
10. Autopsy table with sink
11. Mayo table
12. Scales
13. Footstool
14. Kick bucket
15. Light
16. Hook strip
17. Specimen cabinet with glazed doors
18. Portable observation stand
19. Suction apparatus
20. Ventilating fan
21. Telephone outlet
22. Obscure glass
23. Stretcher
24. View panel
25. Table, 30 x 84 inches
26. Closet

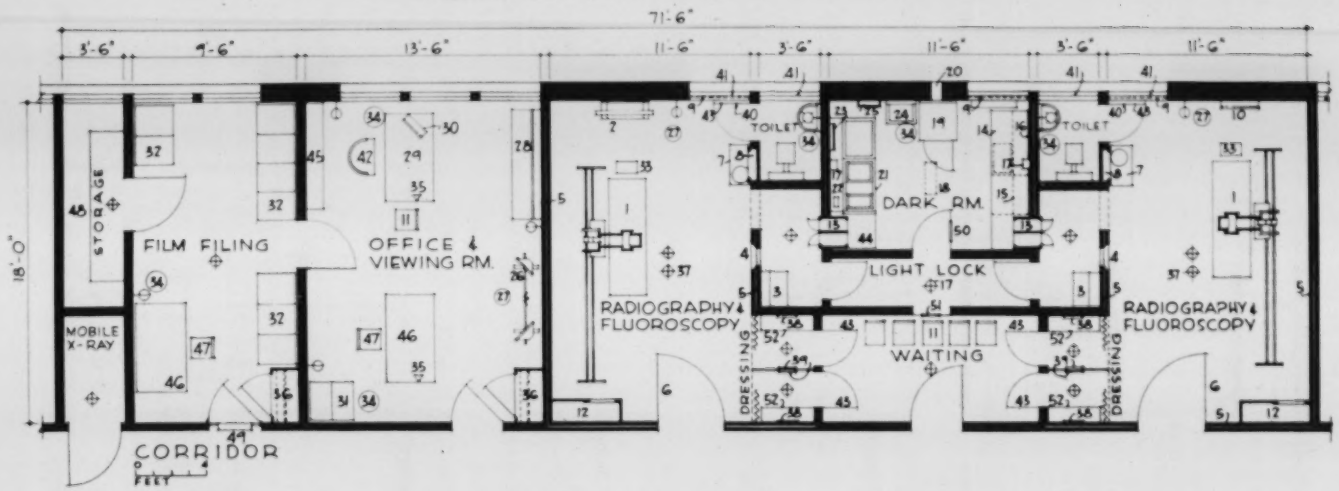
(NOTE: This arrangement is recommended for a 200 bed or larger hospital when facilities are to be utilized by a medical examiner.)

10—*Radiographic Suite for a 50 or 100-Bed General Hospital*

1. Combination radiographic and fluoroscopic unit
2. Cassette changer
3. Control unit
4. Leaded glass view window
5. Lead lining (size and extent varies)
6. Lead-lined door, light proofed
7. Barium sink
8. Recessed cabinet
9. Light-proof shade
10. Low cabinet for supplies
11. Straight chair
12. Storage cabinet
13. Cassette pass box
14. Film loading counter with cabinets below
15. Film storage bin
16. Film hanger racks
17. Safe light
18. Ceiling light, white and red
19. Two-door film dryer
20. Film dryer exhaust
21. Developing tank with thermostatic mixing valve
22. Timer
23. X-ray film illuminator, wall mounted
24. Sink
25. Towel bar
26. Stereoscope
27. Adjustable stool
28. Wall-mounted view box, 2 units of 4 each
29. Executive-type desk
30. X-ray film illuminator
31. Filing cabinet, letter size, 4 drawers
32. Film filing cabinet, 3 drawers
33. Footstool
34. Waste paper receptacle
35. Telephone outlet
36. Costumer
37. Fluoroscopic ceiling light
38. Hook strip
39. Mirror
40. Hook on door
41. Obscure glass
42. Movable partition
43. Light-proofed door
44. Seat

(NOTE: Maze should be painted dull black. If mobile x-ray unit is to be kept in this area, a storage closet should be provided.)





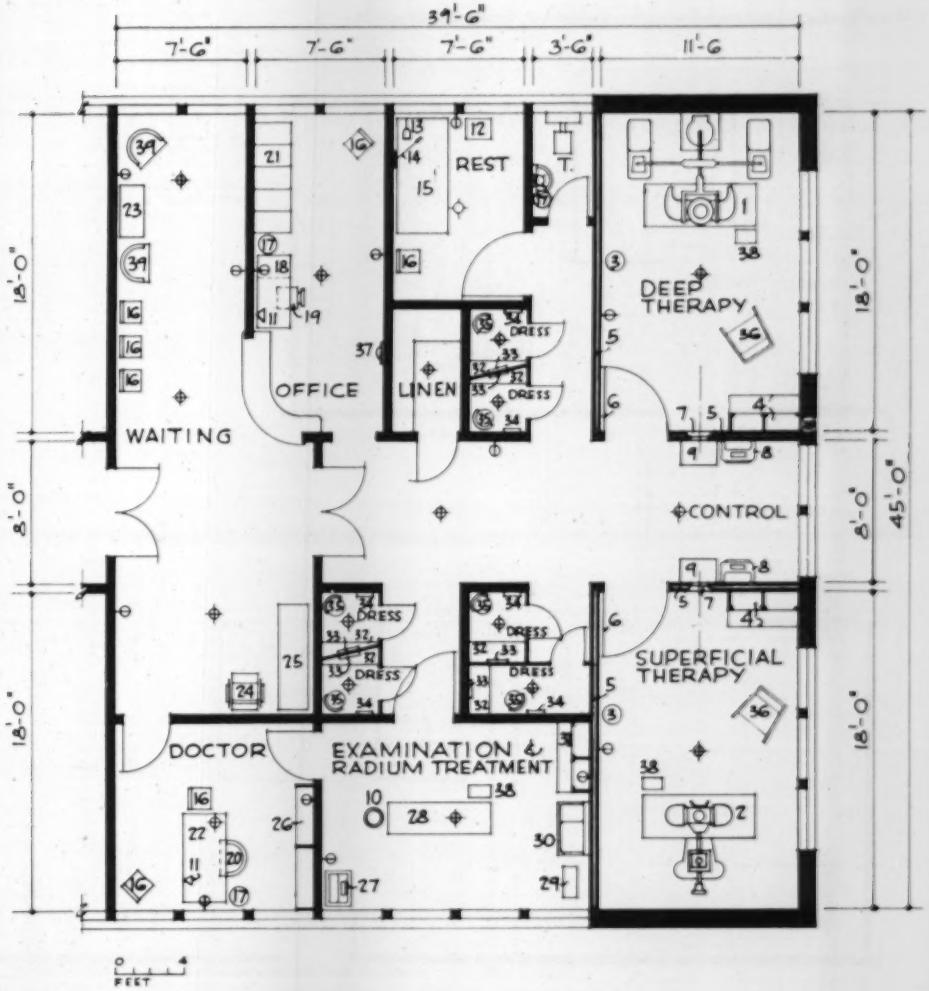
11—Radiographic Suite for a 200-Bed General Hospital

1. Combination radiographic and fluoroscopic unit
2. Cassette changer
3. Control unit
4. Leaded glass view window
5. Lead lining (size and extent varies)
6. Lead-lined door, light proofed
7. Barium sink
8. Recessed cabinet
9. Light-proof shade
10. Cassette tunnel
11. Straight chair
12. Storage cabinet
13. Cassette pass box
14. Film loading counter, 36 inches high, with cabinets, cassette bins and film storage bins below
15. Wall cabinet (bottom 3 feet 8 inches above counter)
16. Film hanger racks
17. Safe light
18. Ceiling light, white and red
19. Film dryer
20. Film dryer exhaust
21. Developing tank with thermostatic mixing valve
22. Timer
23. X-ray film illuminator, wall mounted
24. Sink
25. Towel bar
26. Stereoscope
27. Adjustable stool
28. Wall mounted view box, 2 units of 4 each
29. Executive-type desk
30. X-ray film illuminator
31. Filing cabinet, letter size, 4 drawers
32. Film filing cabinet, 3 drawers
33. Footstool
34. Waste paper receptacle
35. Telephone outlet
36. Closet
37. Fluoroscopic ceiling light
38. Hook strip
39. Mirror
40. Hook on door
41. Obscure glass
42. Executive-type chair
43. Light-proofed door
44. Refrigerating unit
45. Book case
46. Typist's desk
47. Typist's chair
48. Shelving, 18 inches wide
49. Dutch door
50. Door with light-proof louvre in upper panel
51. Door with light-proof louvre in lower panel
52. Seat

(NOTE: Maze should be painted dull black.)

12—X-Ray Therapy Suite for a 200-Bed General Hospital

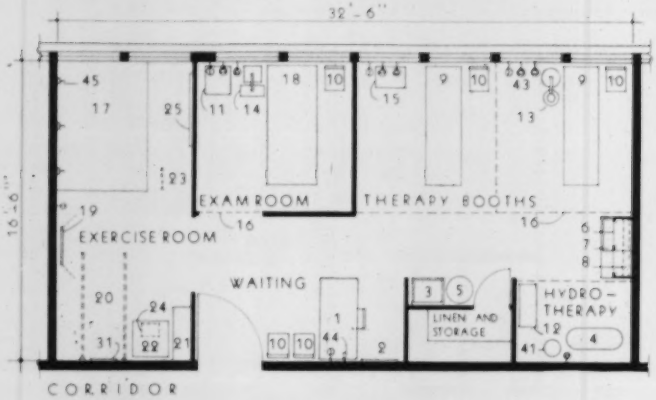
1. Deep therapy unit
2. Superficial therapy unit
3. Adjustable stool
4. Supply cabinet
5. Lead lining (Size and extent varies for floors, walls and ceiling)
6. Lead lined door
7. Leaded glass view window
8. Control unit
9. Counter, 42 inches high
10. Sanitary waste receptacle
11. Telephone outlet
12. Bedside table
13. Bed light
14. Nurses' calling station
15. Bed
16. Straight chair
17. Waste paper receptacle
18. Typewriter desk
19. Typist's chair
20. Desk chair
21. Film filing cabinet
22. Desk
23. Table, 12 x 26 inches
24. Wheel chair
25. Wheel stretcher
26. Bookcase
27. Cautery
28. Examining table
29. Instrument sterilizer, 4 x 6 x 16 inches
30. Combination instrument and scrub sink, with gooseneck spout and knee control
31. Instrument cabinet
32. Shelf, 31 inches high
33. Mirror
34. Hookstrip
35. Stool with back
36. Non-metallic treatment chair
37. Dome light and buzzers
38. Foot stool
39. Easy chair



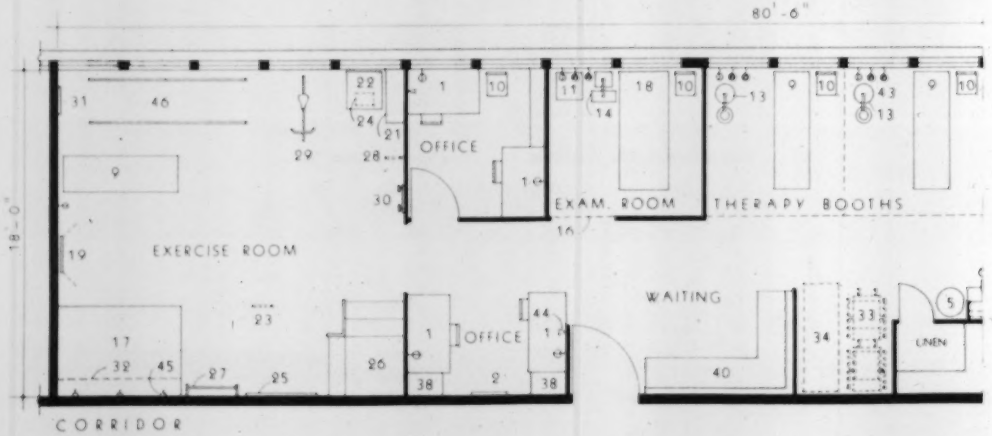
1. Desk
2. Bulletin board
3. Lavatory with gooseneck spout
4. Whirlpool bath
5. Laundry hamper
6. Wall cabinet
7. Sink with drainboard
8. Glass shelf over sink
9. Treatment table with storage space below
10. Chair
11. Bedside table
12. Paraffin bath
13. Infra red lamp
14. Ultra violet lamp
15. Short wave diathermy unit
16. Rod and curtains
17. Gym mat
18. Examination table with storage space below
19. Posture mirror, (triple, portable)
20. Parallel bars, folding type
21. Three shelves, 6, 27, and 48 inches above floor
22. Table, 24 x 24 inches
23. Sayre head sling attached to ceiling
24. Foot rest
25. Shoulder wheel
26. Steps
27. Stall bars
28. Shoulder abduction ladder, arch type
29. Stationary bicycle
30. Pulley weights
31. Wall mirror
32. Shelf 6 feet above floor
33. Wheel chair
34. Wheel stretcher
35. Hubbard tank; a therapeutic pool 8 x 12 feet may replace the hubbard tank by increasing length of suite
36. Monorail over
37. Direct current generators
38. File cabinet
39. Water closet
40. Bench
41. Adjustable stool
42. Hand rail
43. Three single outlets on separate branch circuits, 1 outlet 2-pole, 2 outlets 3-pole
44. Telephone outlet
45. Gym mat hooks
46. Parallel bars

(NOTE: This legend applies to plans 13R, 14R and 15R.)

13R—Physical Therapy Suite for a 50-Bed General Hospital

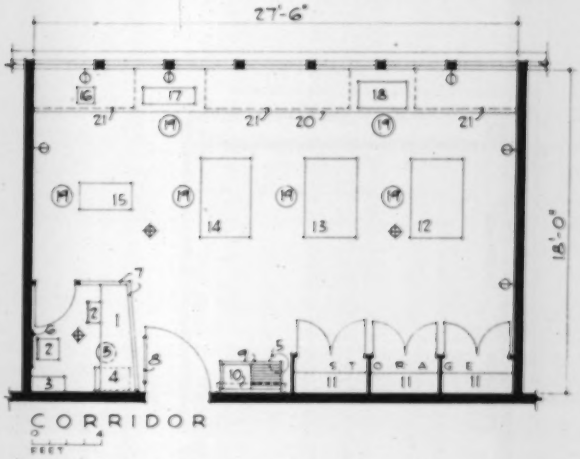


15R—Physical Therapy Suite for a 200-Bed General Hospital

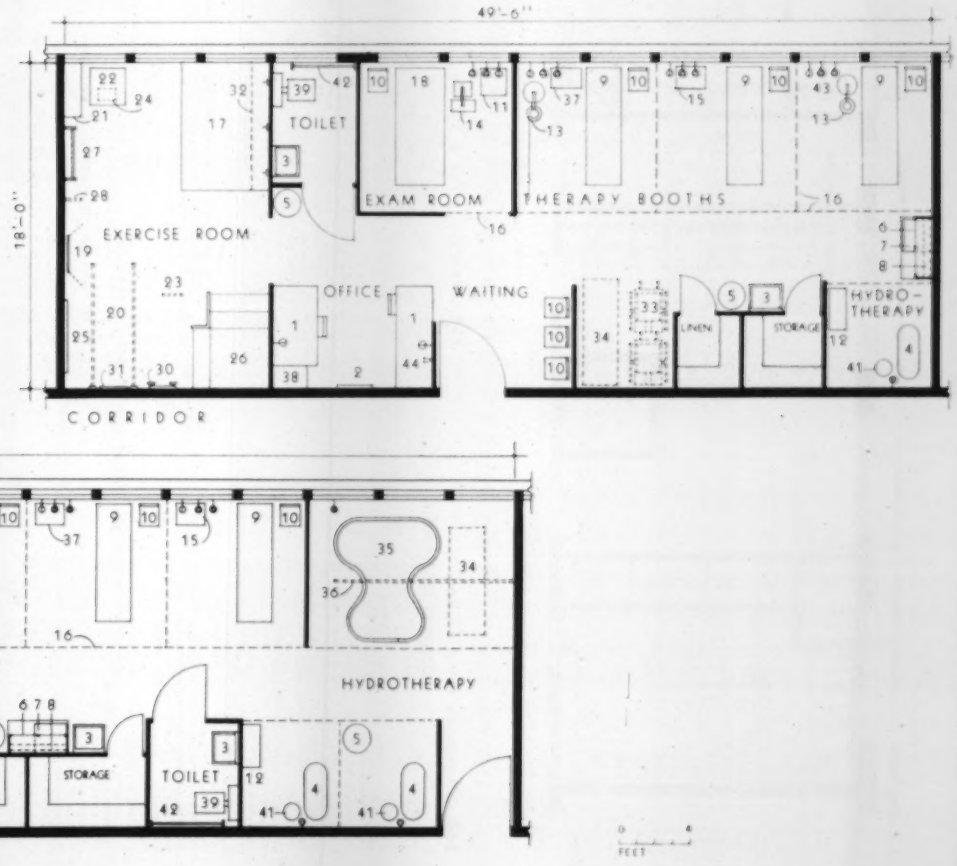


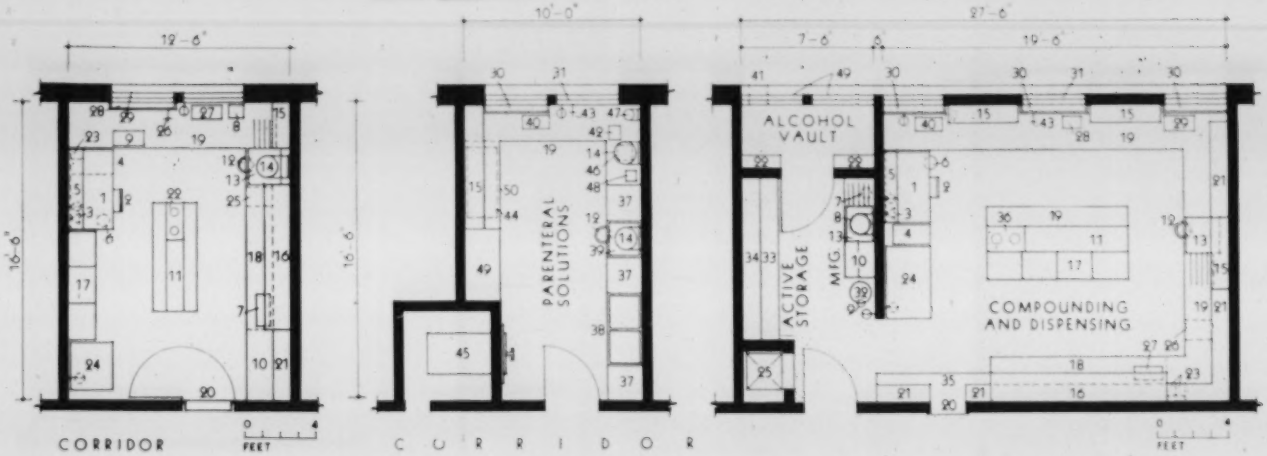
15A—Occupational Therapy Suite for a 200-Bed General Hospital

1. Desk
2. Chair
3. Bookcase
4. Filing cabinet
5. Waste paper receptacle
6. Bulletin board, 26 x 24 inches
7. Glazed partitions
8. Glazed panel
9. Non-staining sink and drainboard
10. Shelf over
11. Adjustable shelves
12. Leather work bench
13. Metal work bench
14. Carpentry work bench
15. Bicycle jig saw
16. Electric grinder
17. Electric lathe
18. Table loom
19. Steel
20. Counter, 36 inches high
21. Storage under counter



14R—Physical Therapy Suite for a 100-Bed General Hospital





16R—Pharmacy for a 50-Bed General Hospital

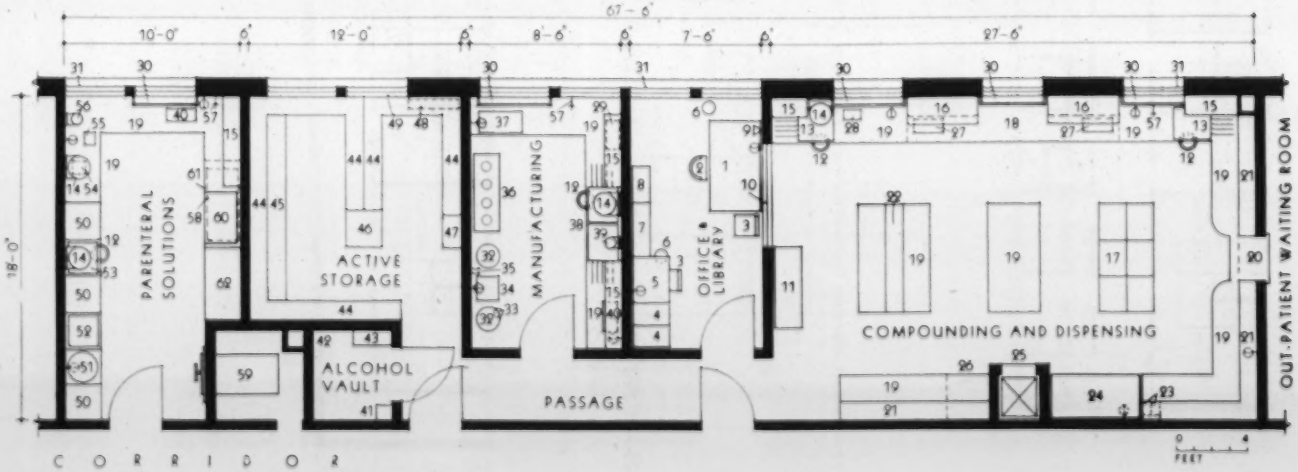
1. Desk
2. Chair
3. Telephone outlet
4. Two-drawer file
5. Book shelves
6. Waste paper receptacle
7. Prescription scale, class A
8. Prescription scale, heavy duty
9. Counter scale
10. Counter, open adjustable shelves below
11. Carboy rack, above counter
12. Sanitary waste can
13. Sink with gooseneck spout and drainboard, graduate rack above, cabinets below
14. Glass tank, distilled water, 5 gallon
15. Cabinet, adjustable shelves
16. Drug cabinet, sectional type, with shelf above counter
17. Drug cabinets, sectional type
18. Prescription counter, cabinets and drawers below
19. Counter, cabinets and drawers below
20. Dutch door
21. Open adjustable shelves, starting 18 inches above counter
22. Filter rack, above counter
23. Prescription file, on desk
24. Refrigerator, 8 cubic feet, with biological drawers
25. Narcotic safe
26. Gas outlet
27. Double element hot plate
28. Heat outlet grill, inlet grill in base of cabinet
29. Guards, at both windows

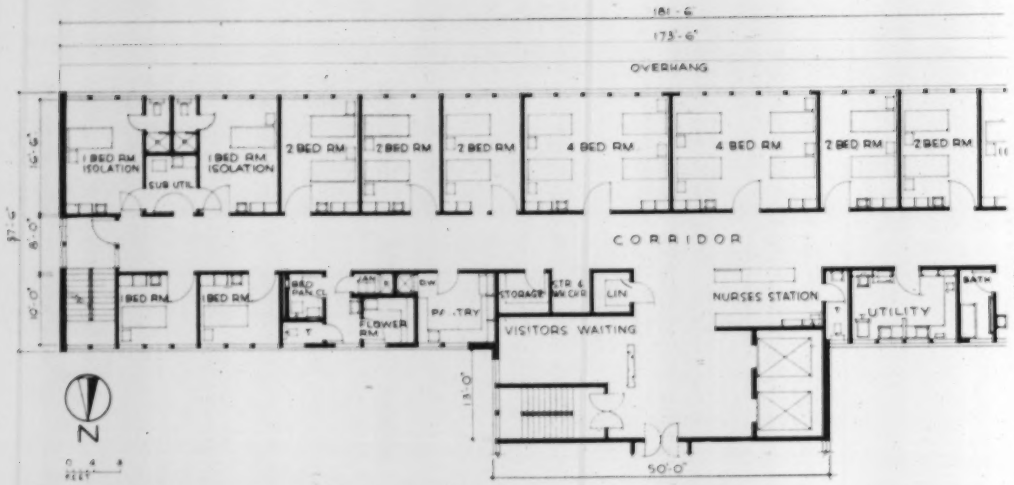
17R—Pharmacy for a 100-Bed General Hospital

1. Desk
2. Chair
3. Telephone outlet
4. File, 4 drawer
5. Book shelves over desk
6. Waste paper receptacle
7. Still, 2-gallon per hour. Required if parenteral solution room is omitted
8. Glass tank, distilled water, 5 gallon
9. Portable electric mixer
10. Counter, cabinets below, shelves above
11. Carboy rack above counter
12. Sanitary waste can
13. Sink with gooseneck spout and drainboard, graduate rack above, cabinets below
14. Glass tank, distilled water, 12 gallon
15. Cabinet adjustable shelves
16. Drug cabinet sectional type, with shelf above counter
17. Drug cabinets, sectional type
18. Prescription counter, cabinets, sectional type drawers below
19. Counter, cabinets and drawers below
20. Dispensing window
21. Adjustable open shelves, starting 18 inches above counter
22. Shelves, starting 42 inches above floor
23. Prescription file
24. Refrigerator, 16 cubic feet, with biological drawers
25. Dumbwaiter
26. Narcotic safe, under counter
27. Prescription scale, class A
28. Prescription scale, heavy duty
29. Counter scale
30. Heat outlet grill, inlet grill in base of cabinet
31. Guards, at all windows
32. Mixing tank, 20 gallons, mounted on stand with casters
33. Counter, 24 inches wide, 36 inches high, adjustable open shelves below
34. Adjustable open shelves, 12 inches wide
35. Counter, 18 inches wide, adjustable shelves below
36. Filter rack above counter
37. Bottle rack
38. Two-compartment sink, gooseneck spout, cabinets below
39. Sink with distilled water rinser, omit hot and cold water supply, cabinets below
40. Double element hot plate
41. Vent at ceiling and floor
42. Metric solution scale
43. Gas outlet
44. Sterilizer carriage under counter
45. Sterilizer, 24 x 36 x 48 inches
46. Drip pan with waste connection in counter top
47. Still, 5 gallons per hour
48. Suction and pressure pump
49. Storage cabinet, open adjustable shelves
50. Counter, open below
51. High window

18R—Pharmacy for a 200-Bed General Hospital

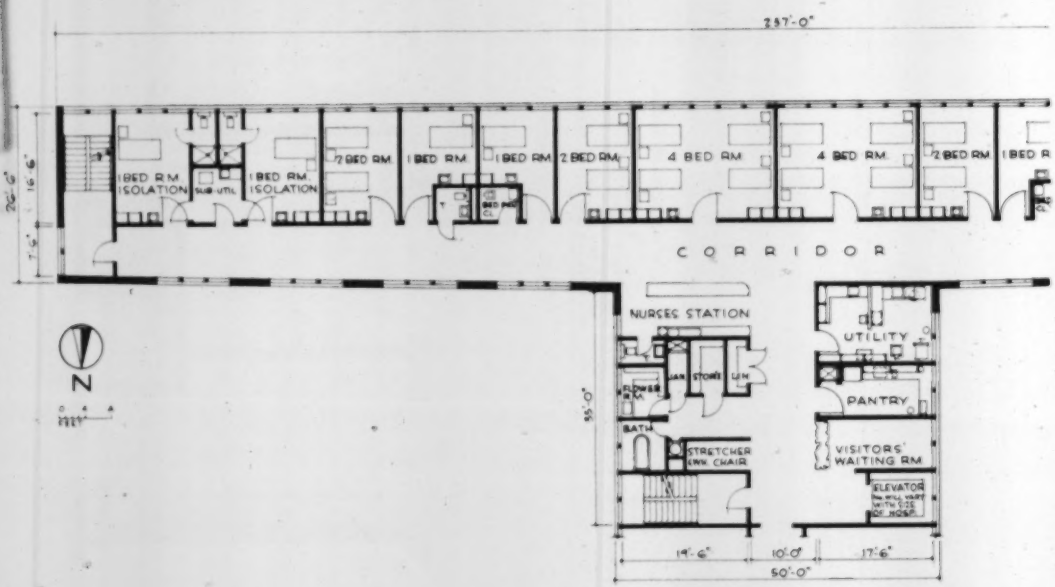
1. Executive desk
2. Executive chair
3. Straight chair
4. Four-drawer file
5. Writing table
6. Waste paper receptacle
7. Book case
8. Magazine rack
9. Telephone outlet
10. Glass panel
11. Carboy rack
12. Sanitary waste can
13. Sink with gooseneck spout and drainboard, graduate rack above, cabinets below
14. Glass tank, distilled water, 12 gallon
15. Cabinets, adjustable shelves
16. Drug cabinet, sectional type, with shelf above counter
17. Drug cabinets, sectional type
18. Prescription counter, cabinets and drawers below
19. Counter, cabinets and drawers below
20. Dispensing window
21. Adjustable open shelves, starting 18 inches above counter
22. Shelf above counter
23. Prescription file
24. Refrigerator with biological drawers, 32 cubic feet
25. Dumbwaiter
26. Narcotics safe, under counter
27. Prescription scale, class A
28. Prescription scale, heavy duty
29. Counter scale
30. Heat outlet grill, inlet grill in base of cabinet
31. Guards, at all windows
32. Mixing or storing tank, 20 gallons, mounted on stand with casters
33. Portable electric mixer
34. Filter press, suction-pressure type, mounted on casters
35. Hot and cold water outlets
36. Filter rack
37. Colloidal mill
38. Two compartment sink with drainboard, gooseneck spout, cabinets below
39. Still, 2 gallon per hour
40. Double element hot plate
41. Vent outlet, 8 inches above floor to atmosphere
42. Vent inlet, near floor to atmosphere
43. Shelves, starting 42 inches above floor
44. Adjustable open shelves, 12 inches wide
45. Counter, 24 inches wide, 36 inches high, adjustable open shelf below
46. Barrel rack
47. Clothes locker
48. Radiator, above shelving
49. High windows
50. Bottle rack
51. Bottle cleaner, pressure type
52. Sink with gooseneck spout
53. Sink with distilled water rinser, omit hot and cold water supply
54. Drip pan with waste connection in counter top
55. Suction and pressure pump
56. Still, 10 gallon per hour
57. Gas outlet
58. Sterilizer carriage, under counter
59. Sterilizer, 24 x 36 x 48 inches
60. Hot air oven, 24 x 14 x 14 inches, on counter
61. Counter, open below
62. Storage cabinet, open adjustable shelves

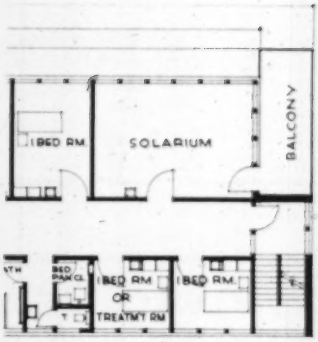




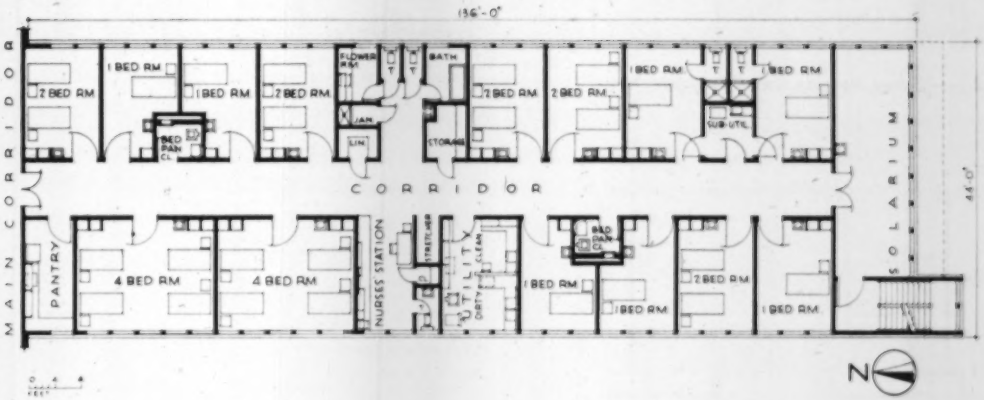
19—25-Bed *Nursing Unit—Southern Exposure with Offset Corridor*

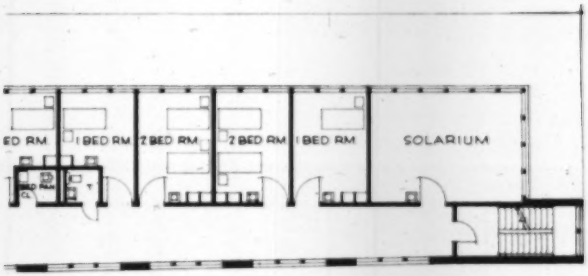
20—25-Bed *Nursing Unit—Southern Exposure*





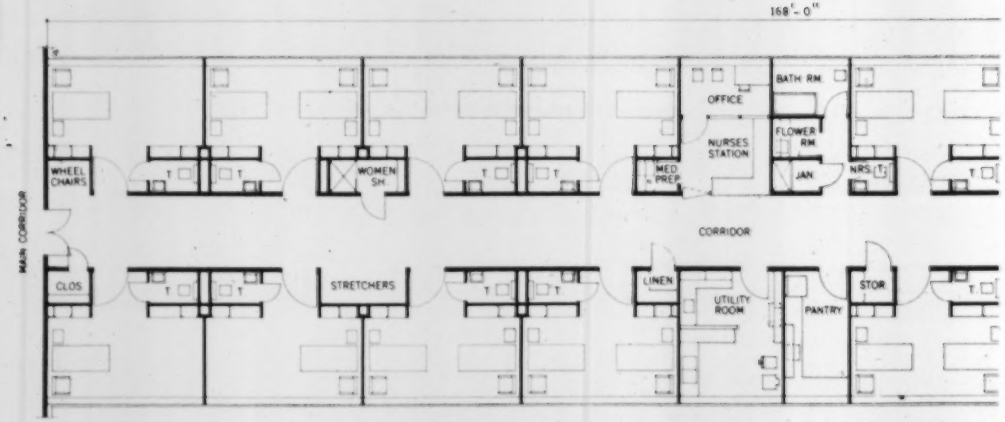
21—25-Bed Nursing Unit—East-West Exposure

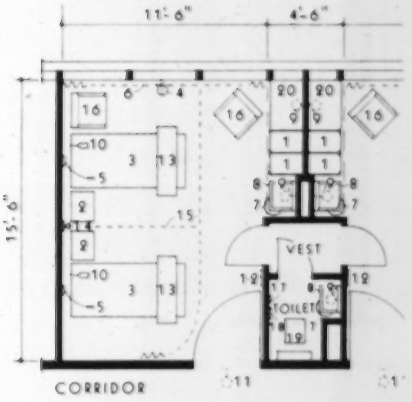




22.1—25-Bed Nursing Unit (Two-Bed Bay)

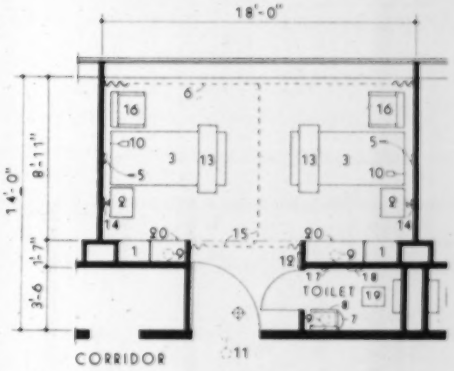
22.3—25-Bed Nursing Unit (One-Bed Bay)



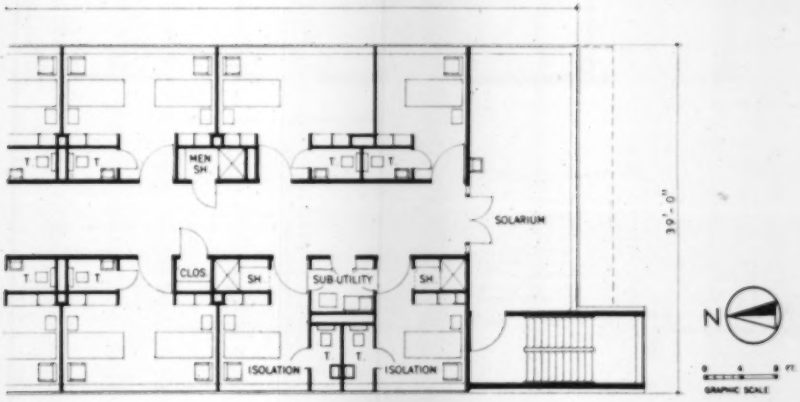


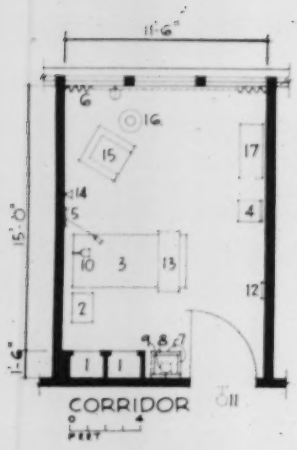
22.2—*Typical Two-Bed Room (Two-Bed Bay)*

1. Built-in locker
2. Bedside table
3. Adjustable hospital bed
4. Duplex convenience outlet
5. Nurses' calling station with duplex receptacle
6. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Wall-bracket light, switch controlled
10. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Over bed table
14. Telephone outlet and duplex receptacle
15. Cubicle rod and curtain
16. Easy chair
17. Nurses' calling station (push-button type)
18. Grab rail
19. Water closet with bedpan lugs and bedpan flushing attachment
20. Built-in dresser



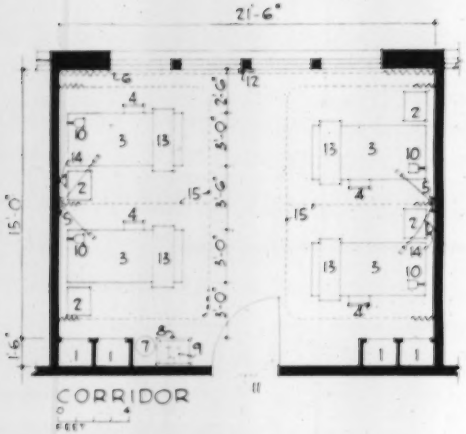
22.4—*Typical Two-Bed Room (One-Bed Bay)*





23—Typical One-Bed Room

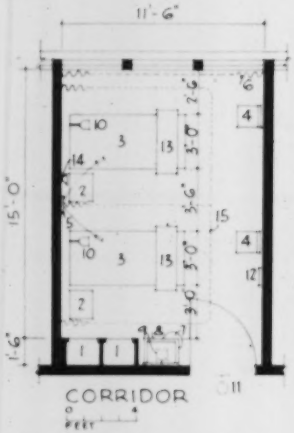
1. Built-in locker
2. Bedside cabinet
3. Adjustable hospital bed
4. Straight chair
5. Nurses' calling station with duplex receptacle
6. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Wall bracket light, switch controlled
10. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Overbed table
14. Telephone outlet
15. Easy chair
16. Floor lamp
17. Dresser



26—Typical Four-Bed Room

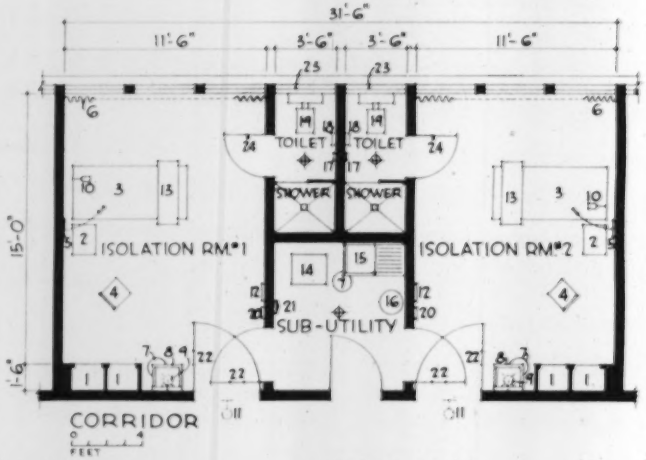
1. Built-in locker
2. Bedside cabinet
3. Adjustable hospital bed
4. Straight chair
5. Nurses' calling station with duplex receptacle
6. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Wall bracket light, switch controlled
10. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Overbed table
14. Telephone outlet
15. Curtain rod and curtain

(NOTE: The length of this room should be 24 feet if it is desired that the room be divided into two two-bed rooms at some later date.)



24—Typical Two-Bed Room

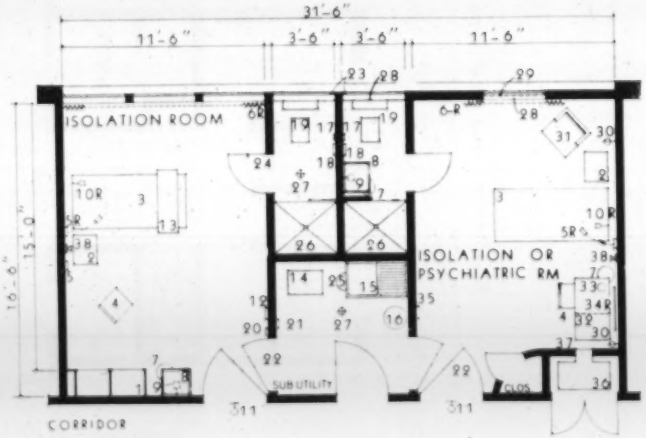
1. Built-in locker
2. Bedside cabinet
3. Adjustable hospital bed
4. Straight chair
5. Nurses' calling station with duplex receptacle
6. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Wall bracket light, switch controlled
10. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Overbed table
14. Telephone outlet
15. Cubicle rod and curtain



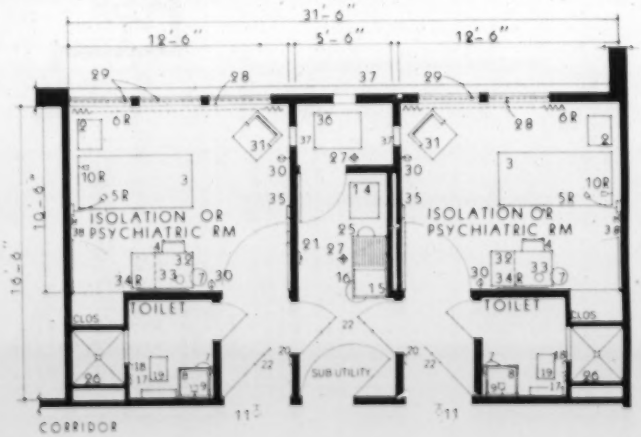
28—Isolation Suite

1. Built-in locker
2. Bedside cabinet
3. Adjustable hospital bed
4. Straight chair
5. Nurses' calling station with duplex receptacle, contagious type
6. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Wall bracket light, switch controlled
10. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Overbed table
14. Utensil sterilizer, 20 x 20 x 24 inches
15. Sink and drainboard
16. Linen hamper
17. Nurses' calling station (push button type)
18. Grab rail
19. Water closet with bedpan lugs and bedpan flushing attachment
20. Hook strip
21. Dome light and buzzer, 5 feet 6 inches above floor
22. View panel
23. Obscure glass
24. Coat hook

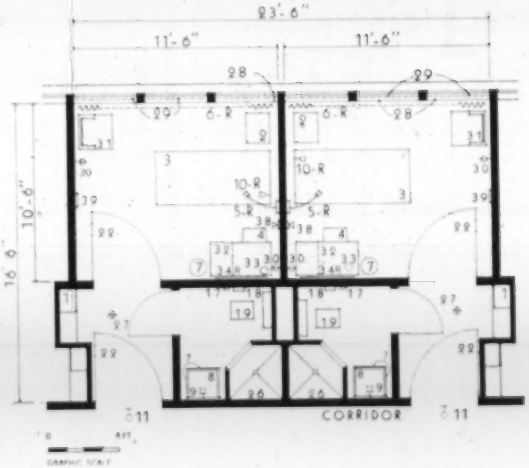
28.1—Isolation and Psychiatric Room, No. 1



28.2—Isolation and Psychiatric Room, No. 2

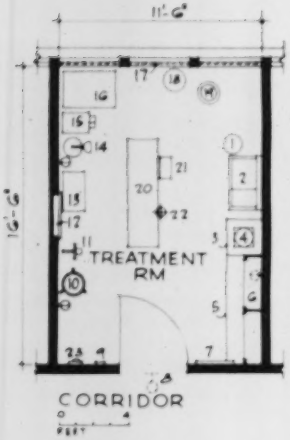


28.3—Private (Special Treatment) Room



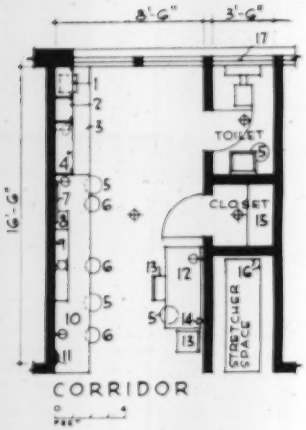
1. Built-in lockers
2. Bedside cabinet
3. Adjustable hospital bed
4. Straight chair
5R. Nurses' calling station with duplex receptacle, contagious type
6R. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Wall bracket, switch controlled
10R. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Overbed table
14. Utensil sterilizer, 20 x 20 x 24 inches
15. Sink and drainboard
16. Linen hamper
17. Nurses' calling station (push-button type)
18. Grab rail
19. Water closet with bedpan lugs and bedpan flushing attachment
20. Hook strip
21. Dome light and buzzer, set 5 feet 6 inches above floor
22. View panel with heat-tempered glass approximately 6 x 12 inches and 4 feet 6 inches from floor
23. Obscure glass
24. Coat hook
25. Sanitary waste receptacle
26. Shower
27. Ceiling light
28. Detention screen
29. Shutter
30. Duplex receptacle
31. Easy chair
32. Desk
33. Desk lamp
34R. Mirror
35. Night light with heat-tempered glass and switch controlled from sub-utility
36. Air conditioning unit
37. Supply and exhaust openings with grille
38. Telephone outlet and duplex receptacle

(Note: All numbers noted with "R" denote that the items shall be removable.)



1. Waste paper receptacle
2. Combination instrument and scrub sink with gooseneck spout and spray and knee control
3. Counter, 29 inches high, open below
4. Single element hot plate
5. Counter, 36 inches high, with cabinets below
6. Wall cabinet
7. Bulletin board, 26 x 24 inches
8. Corridor dome light
9. Nurses' call (connected to nurses' station)
10. Kick bucket
11. Irrigator stand
12. Recessed double x-ray film illuminator
13. Dressing cart
14. Examining light
15. Mayo table
16. Instrument table, 24 x 36 inches
17. Light proof shades
18. Adjustable stool
19. Sanitary waste receptacle
20. Examining table
21. Footstool
22. Ceiling fixture
23. Dome light and buzzer, set 5 feet 6 inches from floor

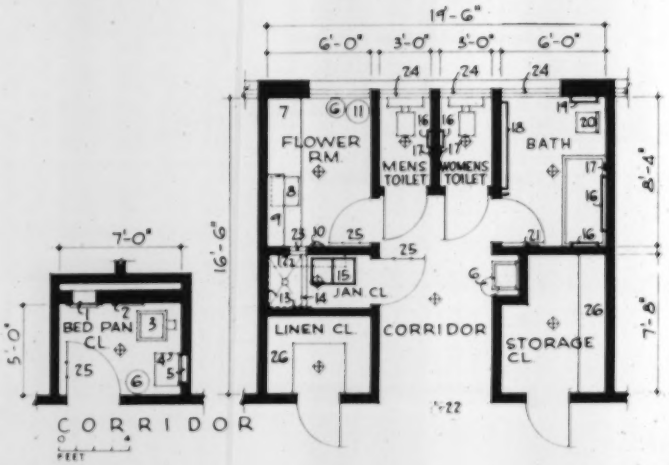
29—Treatment Room for Nursing Floor



30—Nurses' Station and Stretcher Space

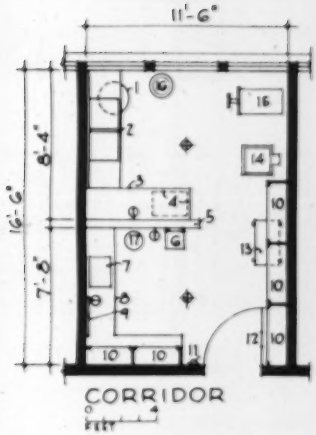
1. Medicine sink in counter with gooseneck spout
2. Locked wall cabinet with inner locked narcotic compartment and inside light
3. Counter, 36 inches high, with cabinets below
4. Wall cabinet
5. Waste paper receptacle
6. Stool
7. Bulletin board, 26 x 24 inches
8. Pigeonhole form rack
9. Chart rack
10. Counter, 30 inches high, open below
11. Dome light and buzzer, set 5 feet 6 inches from floor
12. Nurses' desk
13. Straight chair
14. Telephone outlet
15. Shelving
16. Wheel stretcher
17. Obscure glass

31—Service Group for Nursing Unit



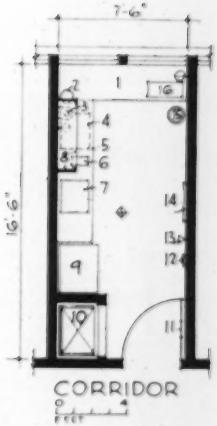
1. Bedpan washer and sterilizer
2. Bulletin board, 26 x 24 inches
3. Clinical sink with bedpan flushing attachment
4. Table, 16 x 20 inches
5. Recessed cabinet
6. Waste paper receptacle
7. Counter, 36 inches high, with open shelving below
8. Sink in counter
9. Two shelves
10. Dome light and buzzer, set 5 feet 6 inches from floor
11. Galvanized iron can
12. Shelf
13. Hook strip for grip sticks
14. Curb
15. Mop truck
16. Grab rail
17. Nurses' calling station (push button type)
18. Drying rod set, 5 feet 6 inches from floor
19. Towel bar
20. Straight chair
21. Hook strip
22. Corridor dome light
23. Ventilating grille
24. Obscure glass
25. Vision panel
26. Shelving

1. Laundry hamper
2. Double compartment laundry tray with drainboards
3. Counter, 36 inches high, open below
4. Cracked ice bin (for external use only)
5. Partition, 4 feet 6 inches high
6. Single element hot plate on bracket
7. Sink in counter with gooseneck spout and knee or elbow control
8. Counter, 36 inches high, with cabinets below
9. Bulletin board, 26 x 24 inches
10. Wall cabinet
11. Dome light and buzzer, set 5 feet 6 inches from floor
12. Vision panel
13. Dressing cart
14. Clinical sink
15. Pressure sterilizer, 16 x 24 inches
16. Sanitary waste receptacle
17. Waste paper receptacle



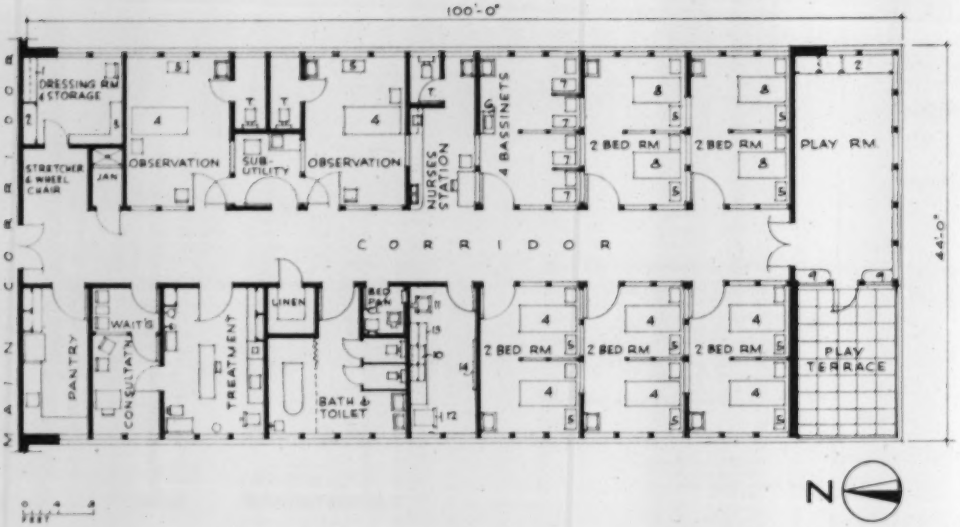
32—Utility Room

1. Counter, 36 inches high, open below
2. Juice extractor
3. Beverage mixer
4. Cracked ice bin
5. Counter, 36 inches high, with cabinets below
6. Electric toaster
7. Sink in counter
8. Wall cabinet
9. Refrigerator, 8 cubic feet
10. Dumbwaiter connected with kitchen
11. Vision panel
12. Dome light and buzzer, set 5 feet 6 inches from floor
13. Telephone connection to kitchen
14. Bulletin board, 26 x 24 inches
15. Sanitary waste receptacle
16. Double element hot plate



33—Floor Pantry (for Centralized Bulk Service)

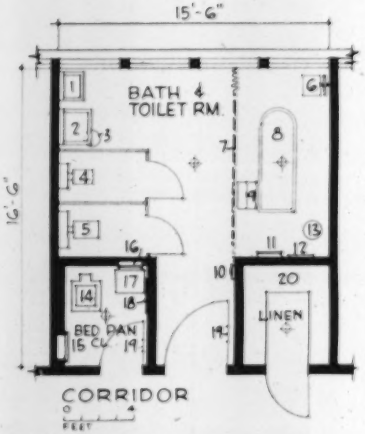
NURSING DEPARTMENT



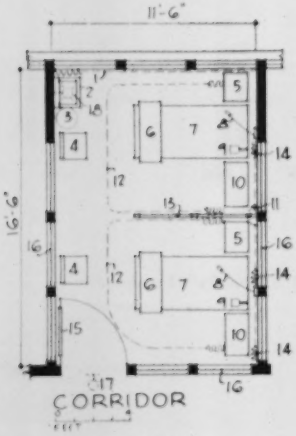
34—Pediatric Nursing Unit

1. Clothes pole with shelf over
2. Storage cabinet
3. Shelving
4. Adjustable hospital bed
5. Toy and clothes cabinet
6. Infant scale
7. Bassinet
8. Crib
9. Toy shelves
10. Double compartment laundry tray and drainboards
11. Clinical sink
12. Pressure sterilizer, 16 x 24 inches
13. Counter, 36 inches high, with cabinets and cracked ice bin below; wall cabinets above
14. Drying rod

(NOTE: Five patient rooms may be added to this unit with no additional service rooms.)



35—Bed Room for Pediatric Unit

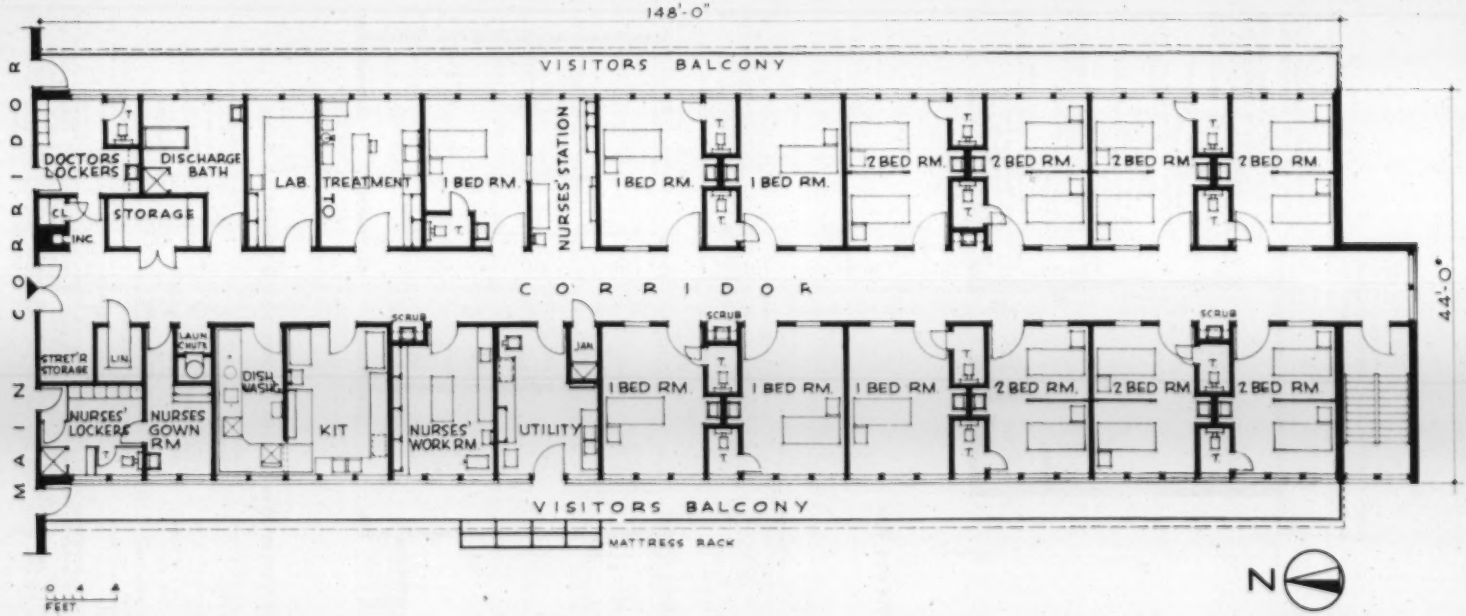


1. Sliding window curtain
2. Lavatory with gooseneck spout and knee or elbow control
3. Waste paper receptacle
4. Straight chair
5. Bedside cabinet
6. Overbed table
7. Adjustable hospital bed*
8. Nurses' calling station with duplex receptacle
9. Bed light
10. Toy and clothes cabinet
11. Indirect wall fixture above top of cubicle partition
12. Cubicle curtain and curtain rod.
13. Cubicle partition, 7 feet high with bottom of clear glass set 36 inches above floor
14. Curtain
15. Door with clear glass in upper panel
16. Clear glass beginning 36 inches above floor
17. Corridor dome light
18. Wall-bracket light, switch controlled

**Cribs may be substituted as required.*

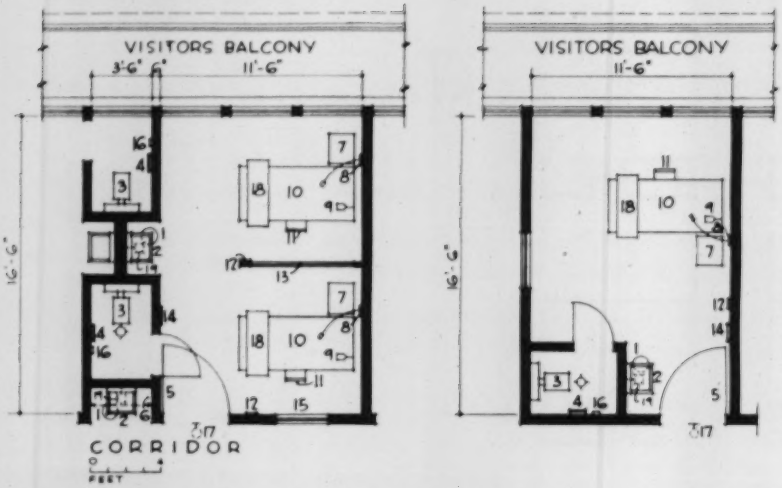
36—Bath Room for Pediatric Unit

1. Lavatory—junior size
2. Lavatory—adult size
3. Waste paper receptacle
4. Water closet—junior size
5. Water closet—adult size
6. Adult scale
7. Curtain and rod
8. Bath tub, pedestal type, with controls on wall
9. Steps
10. Dome light and buzzer, set 5 feet 6 inches from floor
11. Towel bar
12. Hook strip
13. Stool
14. Clinical sink with bedpan flushing attachment
15. Bedpan washer and sterilizer
16. Recessed cabinet
17. Table, 16 x 20 inches
18. Bulletin board, 24 x 24 inches
19. Vision panel
20. Shelving
21. Obscure glass



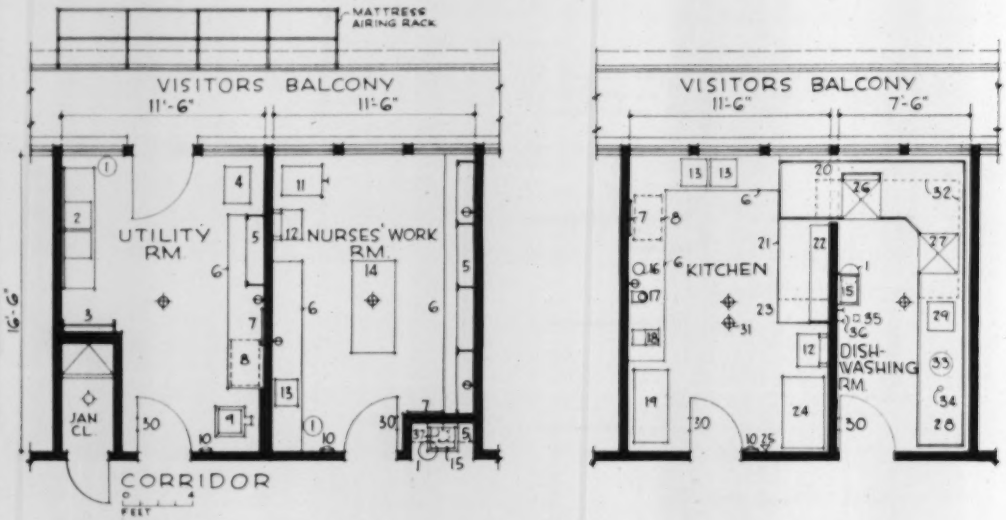
37—Contagious Disease Nursing Unit

NURSING DEPARTMENT



1. Waste paper receptacle
2. Lavatory with gooseneck spout and foot control
3. Water closet with bed pan lugs and bed pan flushing attachment
4. Grab rail
5. Door with clear glass in upper panel
6. Wall cabinet over lavatory
7. Bedside cabinet
8. Nurses' calling station, contagious type with duplex receptacle
9. Bed light
10. Adjustable hospital bed
11. Straight chair
12. Hook strip
13. Cubicle partition, 7 feet high with bottom of clear glass set 36 inches above floor.
14. Night light
15. View window, clear glass
16. Nurses' calling station (push-button type)
17. Corridor dome light
18. Overbed table
19. Wall-bracket light, switch controlled

38—Bed Rooms for Contagious Disease Nursing Unit

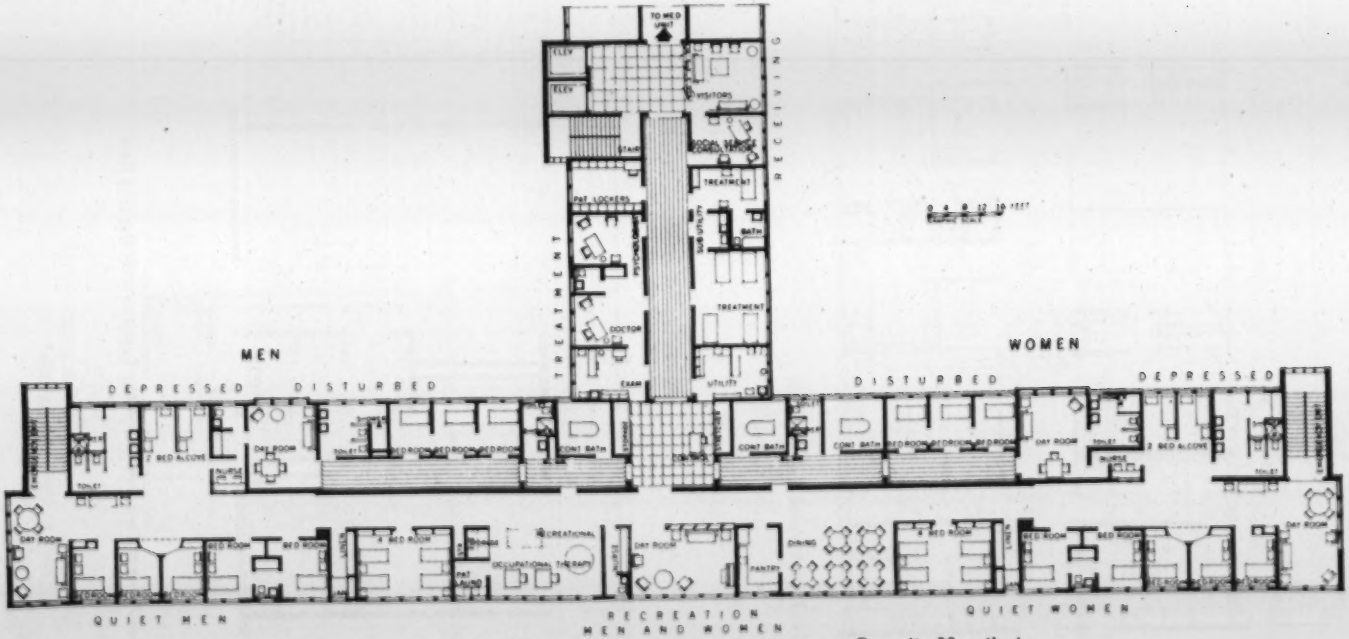


39—Contagious Disease Utility Room and Nurses' Work Room, Kitchen and Dishwashing Room

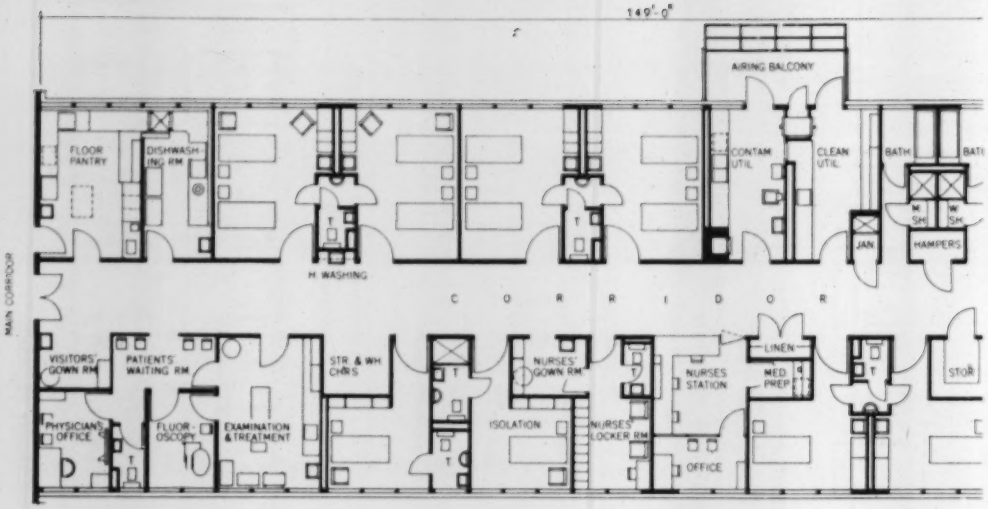
1. Waste paper receptacle
2. Double compartment laundry tray with drainboards
3. Drying rod, 5 feet 6 inches from floor
4. Utensil sterilizer, 20 x 20 x 24 inches
5. Wall cabinet
6. Counter, 36 inches high, with cabinets below
7. Bulletin board, 24 x 24 inches
8. Cracked ice bin (in utility room, for external use only)
9. Clinical sink
10. Dome light and buzzer, set 5 feet 6 inches from floor
11. Dressing sterilizer, 16 x 24 inches
12. Double element hot plate on bracket
13. Sink in counter, 14 inches deep
14. Table, 30 x 60 inches
15. Lavatory with gooseneck spout and foot control
16. Juice extractor
17. Beverage mixer
18. Electric toaster
19. Tray truck
20. Rack return
21. Dish warming compartment below counter
22. Open shelves above counter
23. Tray compartment below counter
24. Refrigerator, 20 cubic feet
25. Telephone outlet
26. Dishwashing machine with heater
27. Dishwashing machine
28. Soiled dish counter
29. Sink, 14 inches deep
30. Vision panel
31. Overhead plug for food cart
32. Hood
33. Food waste grinder
34. Glass brush
35. Floor drain
36. Hot and cold water outlet
37. Wall-bracket light, switch controlled

(NOTE: Heat is the most important factor in the destruction of bacteria during the dishwashing process. A temperature of at least 180 degrees F. is required for effective bactericidal action. The domestic water supply cannot always be depended upon to provide water of required temperature. Therefore the above arrangement has been devised whereby one machine (No. 27) is used for washing dishes at 160 degrees F. The other machine (No. 26) with a thermostatically controlled heater to insure a water temperature of 180 degrees F., is used for final rinsing. With this arrangement dishes can be rinsed for longer periods without diluting or overheating the wash water as would be the case if one single tank machine was used. The washing compartments should be large enough to admit a rack of trays.)

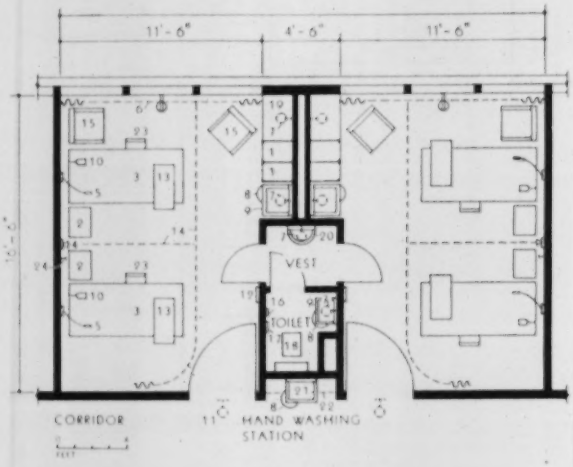
39.1—Psychiatric Nursing Unit, No. 1 For disturbed quiet and depressed men or women. Capacity 20 patients.



39.2—Psychiatric Nursing Unit, No. 2 For disturbed quiet and depressed men and women. Capacity 30 patients.

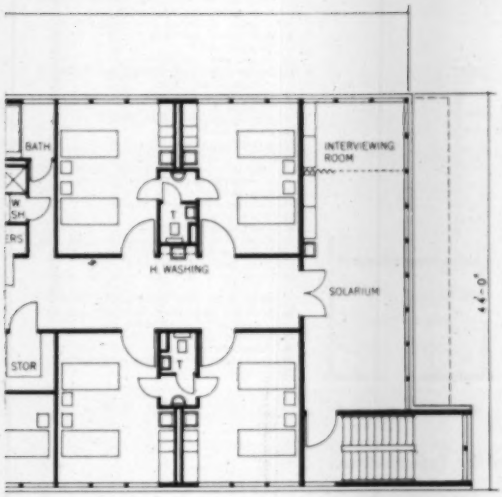


39.3—*Tuberculosis Nursing Unit*

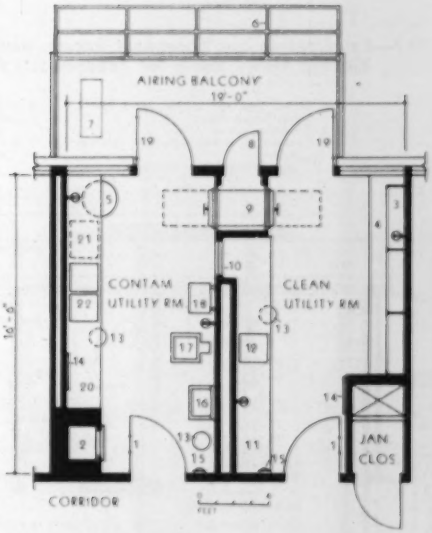


1. Built-in locker
2. Bedside table
3. Adjustable hospital bed
4. Telephone outlet and duplex receptacle
5. Nurses' calling station with duplex receptacle
6. Sliding window curtain
7. Wall bracket light, switch controlled
8. Waste paper receptacle
9. Lavatory with gooseneck spout and knee or elbow control
10. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Overbed table
14. Cubicle rod and curtain
15. Easy chair
16. Nurses' calling station (push button type)
17. Grab rail
18. Water closet with bedpan lugs and bedpan flushing attachment
19. Built-in dresser
20. Dental lavatory
21. Scrub-sink with gooseneck spout and knee or foot control
22. Shelf above scrub sink
23. Straight chair
24. Oxygen and suction outlets, 5 feet 6 inches from floor

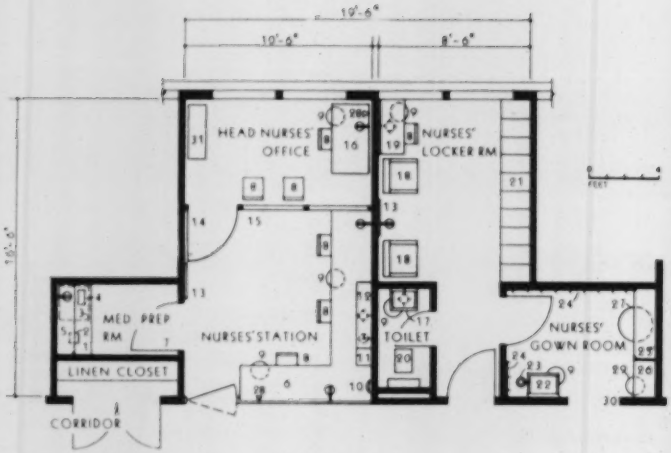
39.4—*Typical Two-Bed Room for Tuberculosis Nursing Unit*



1. Vision panel
2. Incinerator
3. Wall cabinet
4. Counter, 36 inches high, with cabinets below
5. Laundry hamper
6. Mattress airing rack
7. Drying rack
8. Access door
9. Steriliser with double doors, 24 x 36 inches
10. Pass window
11. Counter, 36 inches high, with open shelf below
12. Sink in counter with gooseneck spout and foot or knee control
13. Waste paper receptacle
14. Bulletin board, 26 x 24 inches
15. Dome light and buzzer, set 5 feet 6 inches from floor
16. Scrub sink with gooseneck spout and foot or knee control
17. Clinical sink
18. Hot plate, double element, on bracket
19. Glazed door
20. Counter, 36 inches high, with open shelf below
21. Cracked ice bin (for external use only)
22. Built-in double compartment sink



39.5—*Utility Rooms for Tuberculosis Nursing Unit*

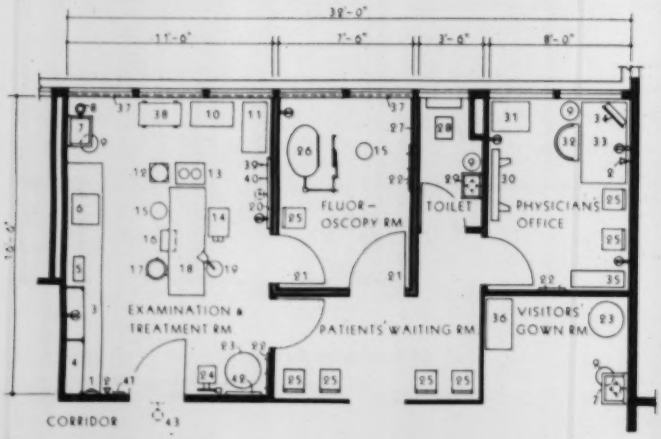


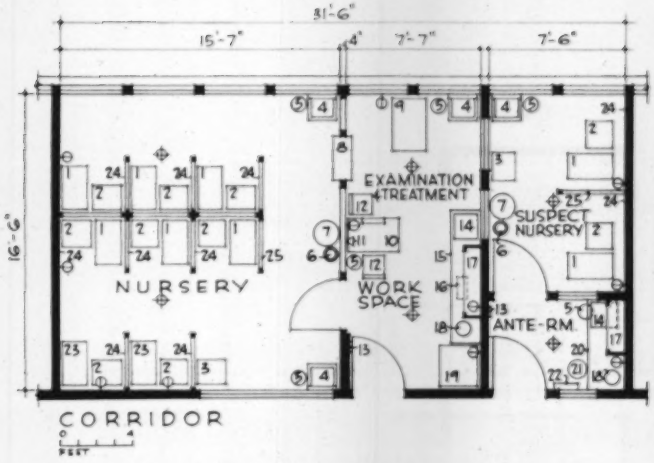
1. Counter, 36 inches high, with shelving under sink for medicine trays
2. Medicine sink in counter with goose-neck spout
3. Refrigerator under counter
4. Instrument sterilizer, 3 x 3½ x 8½ inches
5. Wall cabinet with inner locked narcotic compartment and inside light
6. Counter, 30 inches high, open below
7. Dutch door with lock
8. Straight chair
9. Waste paper receptacle
10. Dome light and buzzer, set 5 feet 6 inches from floor
11. Pigeon-hole form rack
12. Chart rack
13. Bulletin board, 26 x 24 inches
14. Glazed door
15. Glazed partition
16. Desk
17. Lavatory with gooseneck spout and knee or elbow control
18. Easy chair
19. Counter with mirror above
20. Water closet
21. Lockers, full length
22. Scrub sink with gooseneck spout and foot or knee control
23. Soap dispenser with foot control
24. Hook strip with name plates above hooks
25. Wall cabinet for clean gowns
26. Shelf for clean mask container and for-caps jar, mirror above shelf
27. Laundry hamper
28. Telephone outlet
29. Receptacle for contaminated masks
30. Trimmed opening

39.6—Nurses' Station, Locker Room and Gown Room for Tuberculosis Nursing Unit

39.7—Examination and Treatment Rooms, and Visitors' Gown Room for Tuberculosis Nursing Unit

1. Dome light and buzzer, set 5 feet 6 inches from floor
2. Telephone outlet
3. Counter, 36 inches high, with cabinets below
4. Wall cabinet
5. Instrument sterilizer, 17½ x 7½ 6 inches
6. Built-in instrument sink with goose-neck spout and foot or knee control
7. Scrub sink with gooseneck spout and foot or knee control
8. Soap dispenser, single, with foot control
9. Waste paper receptacle
10. Clean-up table, 18 x 30 inches
11. Instrument table, 18 x 33 inches
12. Single basin stand
13. Pneumothorax apparatus with stand
14. Mayo table
15. Adjustable stool
16. Footstool
17. Kick bucket
18. Examination table
19. Examination light
20. Film illuminator, 2 units of 3 each, built-in
21. Lead lined door
22. Hook strip
23. Laundry hamper
24. Clinical scale
25. Straight chair
26. Fluoroscope
27. Lead lined walls
28. Water closet
29. Lavatory with gooseneck spout and foot or knee control
30. Mobile film illuminator stand
31. Film file
32. Desk chair
33. Executive-type desk
34. View box
35. Bookcase
36. Table for clean gowns
37. Light-proof shades
38. Dressing cart
39. Suction outlet, 5 feet 6 inches from floor
40. Oxygen outlet, 5 feet 6 inches from floor
41. Nurses' call (connected to nurses' station)
42. Bulletin board, 26 x 24 inches
43. Corridor dome light

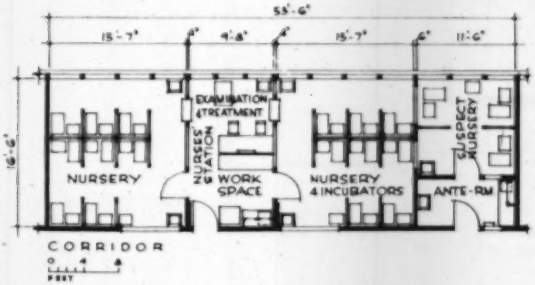




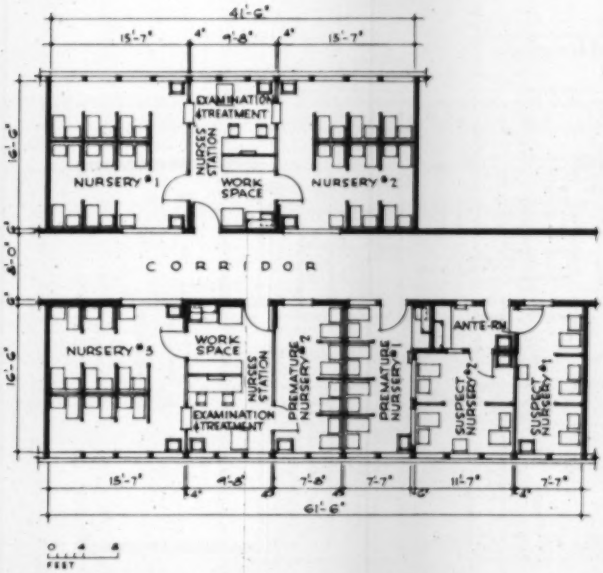
40—*Nursery for a 50-Bed General Hospital*

1. Bassinet
2. Bedside cabinet
3. Table, 16 x 24 inches (for infant scale)
4. Lavatory with gooseneck spout and knee control
5. Waste paper receptacle
6. Sanitary waste receptacle
7. Linen hamper
8. Pass window with shelf and sliding sash
9. Table, 24 x 36 inches
10. Nurses' desk with chart rack for 8 charts
11. Telephone outlet
12. Straight chair
13. Hook strip
14. Sink in counter with gooseneck spout and knee control
15. Counter, 36 inches high, with cabinets below
16. Instrument sterilizer, 4 x 6 x 16 inches
17. Wall cabinet
18. Single element hot plate
19. Refrigerator, 6 cubic feet
20. Counter, 36 inches high, open below
21. Stool
22. Chart rack for 2 charts
23. Incubator
24. Gown hook
25. Cubicle partitions, 5 feet 6 inches high, clear glass in upper panels

(NOTE: Where use of large incubators is contemplated, cubicle size should be increased accordingly.)



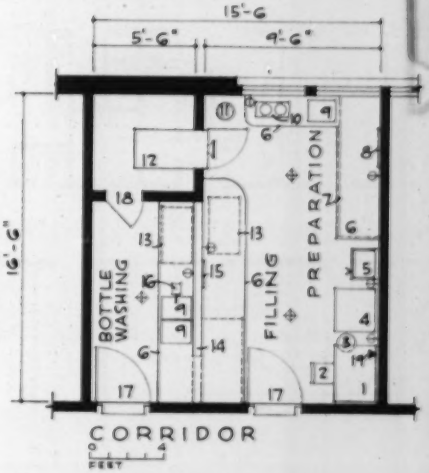
41—*Nursery for a 100-Bed General Hospital*

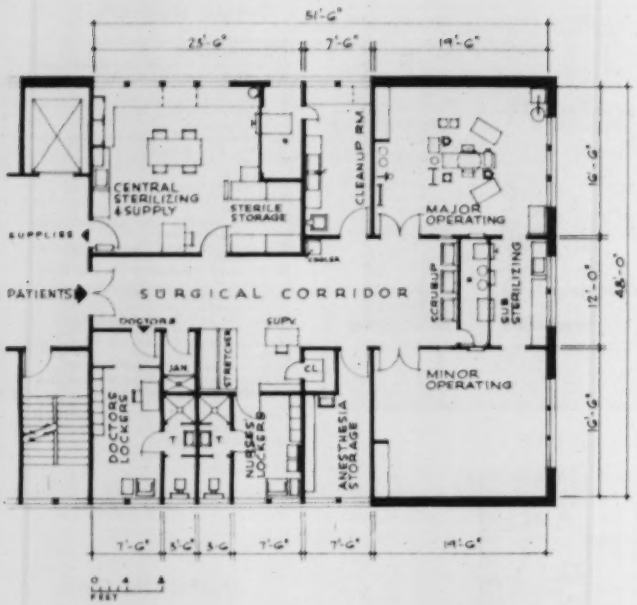


42—*Nursery for a 200-Bed General Hospital*

43—*Formula Room*

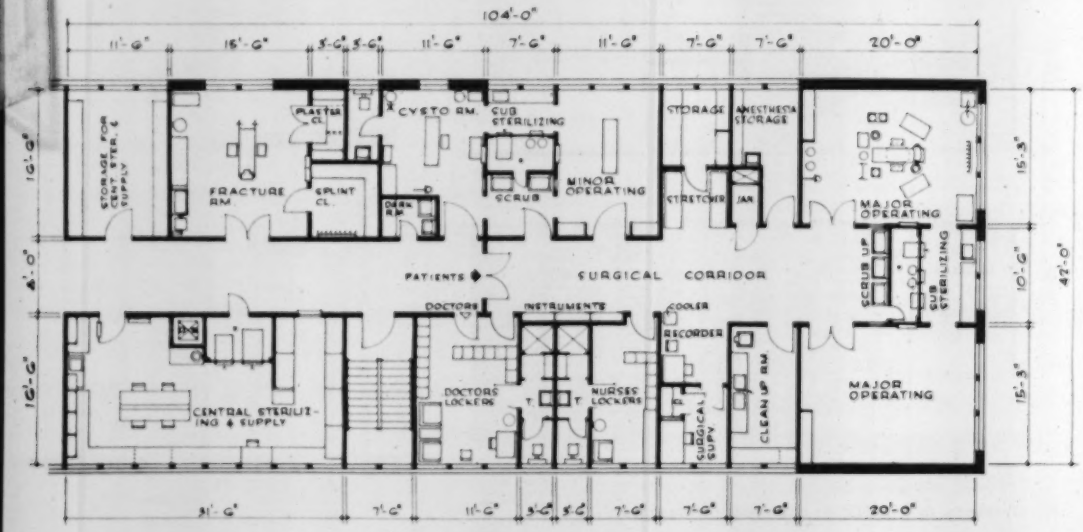
1. Desk
2. Chair
3. Waste paper receptacle
4. Refrigerator
5. Lavatory with knee control
6. Counter, 36 inches high
7. Cabinets under counter
8. Bulletin board, 26 x 24 inches
9. Sink
10. Two-element hot plate
11. Sanitary waste receptacle
12. Rectangular pressure sterilizer, nickel clad
13. Milk cart
14. Partition, 5 feet high
15. Holder for formula record book
16. Electric bottle washer
17. Dutch door
18. Access door
19. Telephone outlet

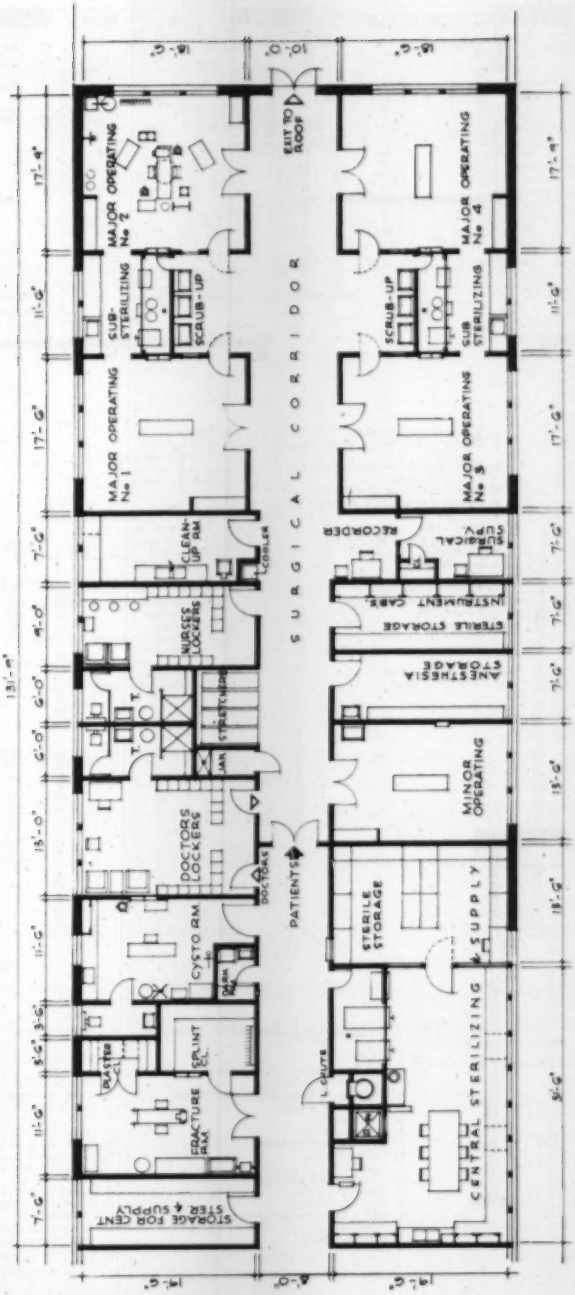




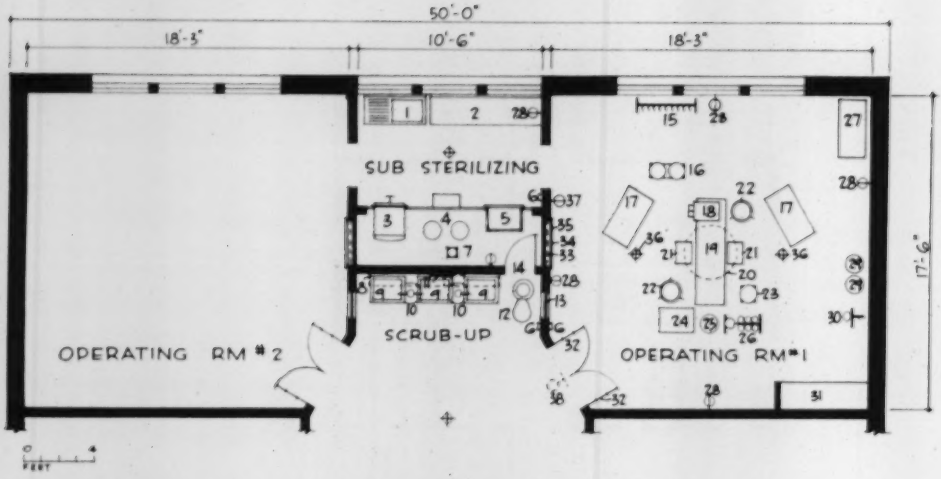
44—Operating Suite for a 50-Bed General Hospital

45—Operating Suite for a 100-Bed General Hospital



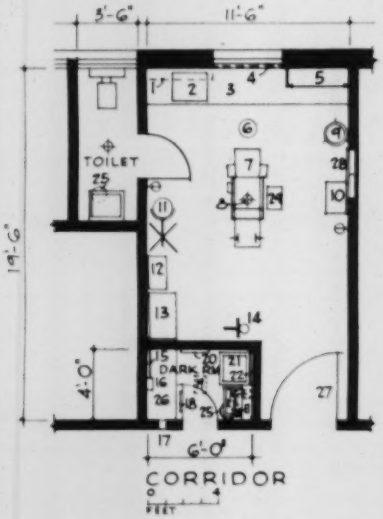


46—Operating Suite for a 200-Bed General Hospital



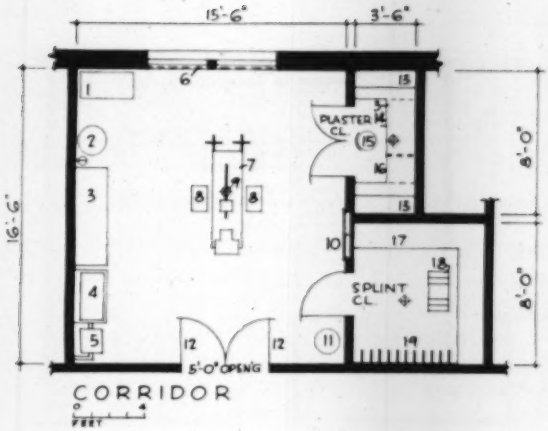
47—*Operating Rooms*

1. Sink and drainboard
2. Counter, 36 inches high, open below
3. High speed pressure sterilizer, 16 x 24 inches
4. Water sterilizers, 15 gallons each
5. Blanket and solution warmer
6. Mercury switch
7. Floor drain
8. Glass shelf over scrub sinks
9. Scrub sink
10. Soap dispenser
11. Clock
12. Alcohol dispenser
13. View window, clear glass
14. Access door
15. Sponge rack
16. Double basin stand
17. Instrument table, 24 x 48 inches
18. Mayo table
19. Operating table
20. Operating light
21. Footstool
22. Kick bucket
23. Single basin stand
24. Anesthetist's table
25. Anesthetist's stool
26. Anesthesia unit
27. Pack table
28. Explosion proof electric outlet
29. Adjustable stool
30. Irrigator stand
31. Adjustable open shelving, 18 inches wide
32. Vision panel
33. Clock
34. Recessed double x-ray film illuminator
35. Aspirator
36. Flush ceiling fixture for general illumination
37. Explosion proof ceiling station, foot operated
38. Corridor dome light



48—*Cystoscopic Room*

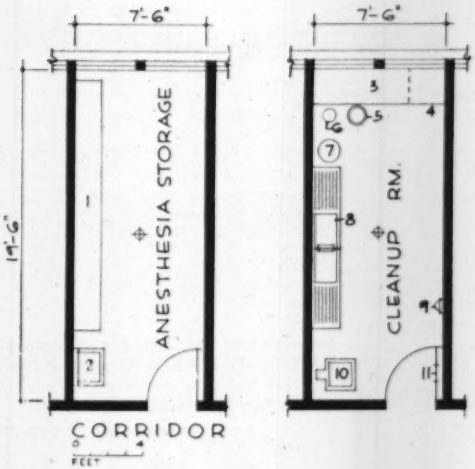
1. Shelf
2. Sink in counter with gooseneck spout and knee control
3. Counter, 36 inches high, open below
4. Light proof shade
5. Wall cabinet
6. Adjustable stool
7. Urological x-ray table
8. Ceiling light
9. Kick bucket
10. Wheeled catheter tray
11. Examining light
12. Electric cautery
13. Urological instrument cabinet, 19 x 30 inches
14. Irrigator stand
15. Film hanger rack above counter
16. Safelight
17. Exhaust fan
18. Light proofed door with light proof louvre
19. Ceiling light, white and red
20. Towel bar
21. Developing tank, 18 x 22 inches
22. Film drying bracket for 12 films
23. Sink with shelf over
24. Timer
25. Waste paper receptacle
26. Counter, 36 inches high, with cabinets below
27. Light-proof door
28. Double recessed view box
29. Footstool



1. Instrument table, 18 x 36 inches
2. Galvanized iron can
3. Counter, 36 inches high, open below
4. Plaster sink
5. Plaster trap
6. Light proof shade
7. Fracture table
8. Footstool
9. Ceiling fixture
10. Recessed double x-ray film illuminator
11. Linen hamper
12. Light-proof door
13. Three shelves, 12 inches wide
14. Plaster drawer, 3 inches deep, open below
15. Adjustable stool with back
16. Plaster bin
17. Six shelves, 18 inches wide
18. Step ladder
19. Two rows of ¾ inch diameter dowels, 12 inches o.c., staggered; top row, 6 feet from floor, bottom row, 5 feet from floor

(NOTE: Corridor doors should be light proofed.)

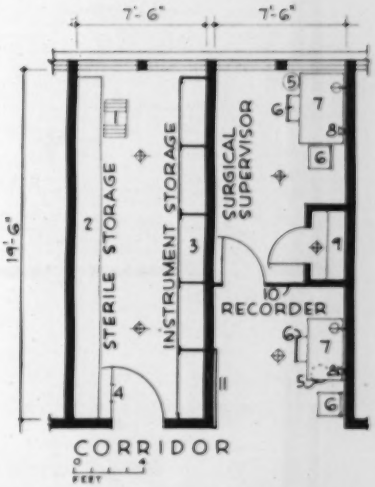
49—*Fracture Room*



50—*Anesthesia Storage and Cleanup Rooms*

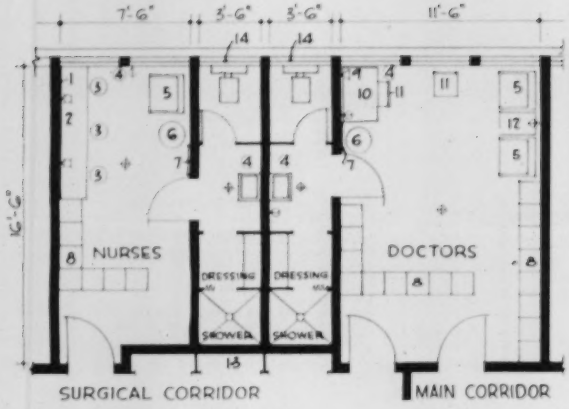
1. Shelving, 18 inches wide
2. Sink with gooseneck spout and knee or elbow control
3. Counter, 36 inches high, open below
4. Cabinet below counter, 2 feet wide
5. Sanitary waste receptacle
6. Waste paper receptacle
7. Linen hamper
8. Double compartment laundry tray with drainboards
9. Dome light and buzzer, set 5 feet 6 inches from floor
10. Clinical sink
11. Vision panel

(NOTE: Radiator to be omitted in Anesthesia Room.)



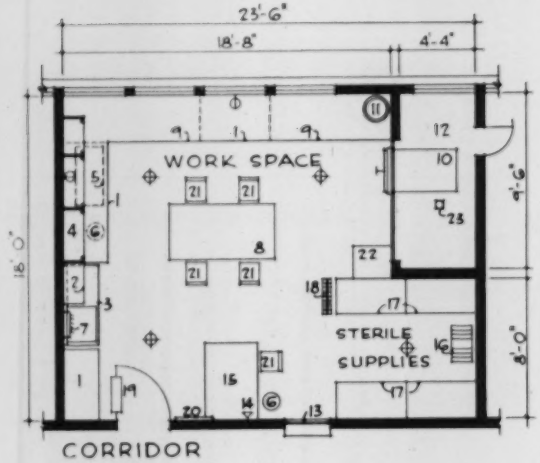
51—*Instrument and Sterile Supply Room, Surgical Supervisor and Recorder for a 200-Bed General Hospital*

1. Step ladder
2. Shelving, 18 inches wide
3. Instrument cabinet
4. Vision panel
5. Waste paper receptacle
6. Straight chair
7. Desk
8. Telephone outlet
9. Shelving, 12 inches wide
10. Glazed door and partition, clear glass
11. Blackboard



52—Doctors' and Nurses' Locker Rooms in Surgical Suite

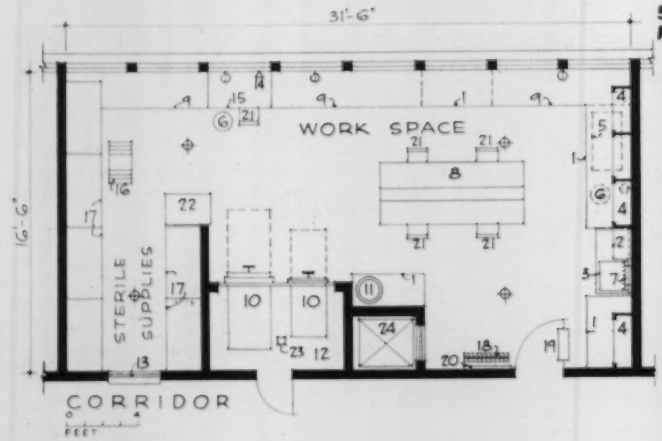
1. Mirror, 84 x 24 inches, above counter
2. Counter, 30 inches high, open below
3. Stool, 18 inches high
4. Waste paper receptacle
5. Easy chair
6. Linen hamper
7. Bulletin board, 26 x 24 inches
8. Lockers
9. Telephone outlet
10. Desk
11. Straight chair
12. End table
13. Instrument cabinets
14. Obscure glass



53—Central Sterilizing and Supply Room for a 50-Bed General Hospital

1. Counter, 36 inches high, open below
2. Shelf
3. Sink and drainboard
4. Wall cabinet
5. Supply cart
6. Waste paper receptacle
7. Multiple rubber tube washer
8. Table, 42 x 72 inches
9. Counter, 36 inches high, cabinets and drawers below
10. Dressing sterilizer, 24 x 24 x 36 inches
11. Water still, capacity 5 gallons per hour
12. Ventilated mechanical space
13. Pass window
14. Telephone outlet
15. Desk
16. Step ladder
17. Sterile supply cabinets
18. Glove drying rack
19. Dutch door
20. Bulletin board, 26 x 24 inches
21. Straight chair
22. Hot air sterilizer, 18 x 14 x 14 inches
23. Floor drain

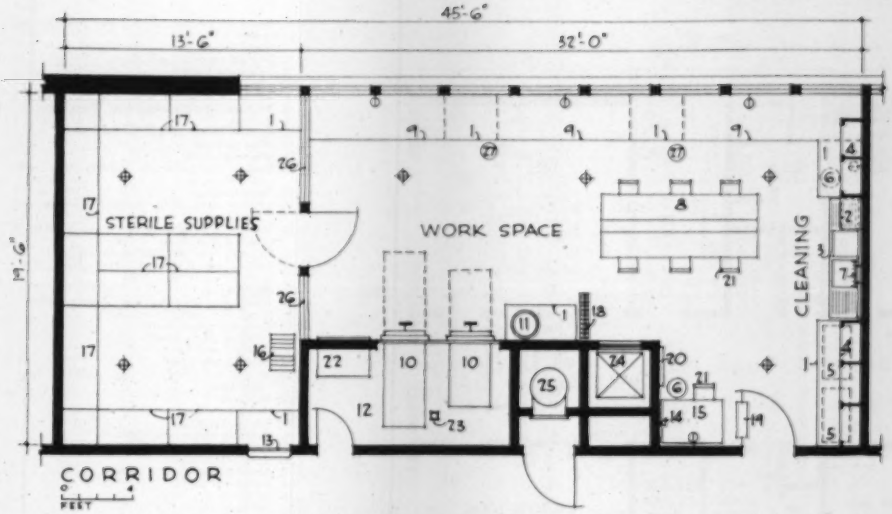
(NOTE: Convenient to this room provide a storage room for unsterile supplies and equipment.)



54—Central Sterilizing and Supply Room for a 100-Bed General Hospital

1. Counter, 36 inches high, open below
2. Shelf
3. Sink and drainboard
4. Wall cabinet
5. Supply cart
6. Waste paper receptacle
7. Multiple rubber tube washer
8. Table with shelf over, 42 x 96 inches
9. Counter, 36 inches high, cabinets and drawers below
10. Dressing sterilizers: 1—24 x 24 x 36 inches—1—20 x 36 inches
11. Water still, capacity 5 gallons per hour
12. Ventilated mechanical space
13. Pass window
14. Telephone outlet
15. Built in desk, 30 inches high with drawer
16. Step ladder
17. Sterile supply cabinet
18. Glove drying rack
19. Dutch door
20. Bulletin board, 26 x 24 inches
21. Straight chair
22. Hot air sterilizer, 24 x 14 x 14 inches
23. Floor drain
24. Dumb waiter

(NOTE: Convenient to this room provide a storage room for unsterile supplies and equipment.)



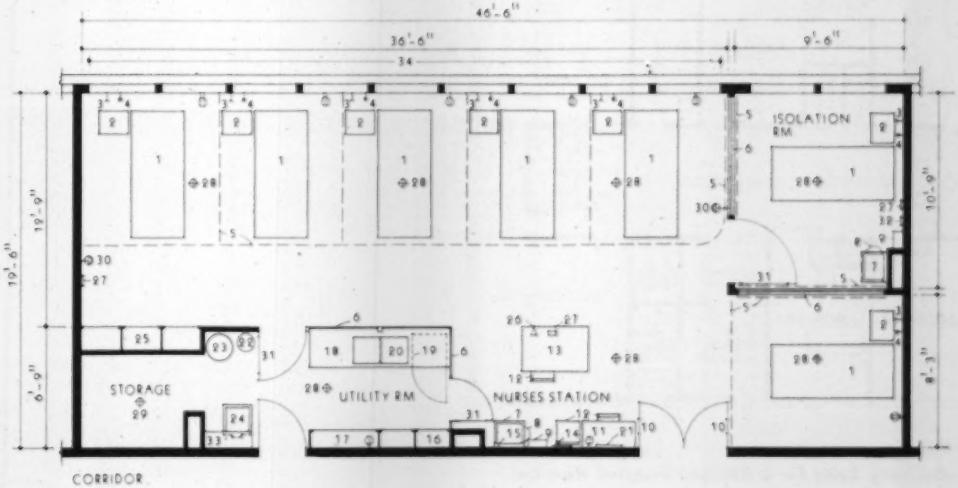
55—*Central Sterilizing and Supply Room for a 200-bed General Hospital*

1. Counter, 36 inches high, open below
2. Shelf
3. Sink and drainboard
4. Wall cabinet
5. Supply cart
6. Waste paper receptacle
7. Multiple rubber tube washer
8. Table with shelf over, 42 x 96 inches
9. Counter, 36 inches high, cabinets and drawers below
10. Dressing sterilizers; 1—24 x 36 x 48 inches, 1—24 x 24 x 36 inches
11. Water still, capacity 5 gallons per hour
12. Ventilated mechanical space
13. Pass window
14. Telephone outlet
15. Desk
16. Step ladder
17. Sterile supply cabinet
18. Glove drying rack
19. Dutch door
20. Bulletin board, 26 x 24 inches
21. Straight chair
22. Hot air sterilizer, 30 x 24 x 18 inches
23. Floor drain
24. Dumb waiter
25. Laundry chute
26. Glazed partitions
27. Adjustable stool

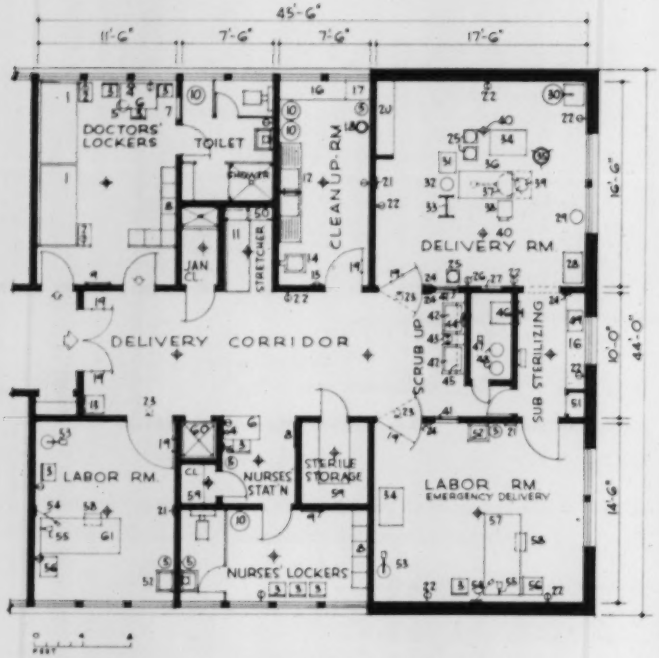
(NOTE: Convenient to this room provide a storage room for unsterile supplies and equipment.)

55.1—*Recovery Room for a 200-Bed General Hospital*

1. Adjustable hospital bed
2. Bedside cabinet
3. Oxygen outlet, 5 feet 3 inches above floor
4. Suction outlet, 5 feet 3 inches above floor
5. Cubicle curtain
6. Partition to ceiling, glass 40 inches above floor to 7 feet above floor
7. Lavatory with goosenack spout and knee or elbow control
8. Waste paper receptacle
9. Paper towel dispenser
10. Vision panel
11. Table
12. Straight chair
13. Executive type desk
14. Clock
15. Mirror
16. Locked wall cabinet with inner locked narcotic compartment and inside light
17. Shelf, 12 inches wide, 38 inches above floor with cabinets above and below
18. Work counter, 2 feet 4 inches wide, 38 inches above floor
19. Refrigerator under counter
20. Double compartment sink, one compartment 6 inches deep, the other 10 inches deep, goosenack spout
21. Bulletin board
22. Sanitary waste receptacle
23. Laundry hamper
24. Clinical sink with bedpan flushing attachment
25. Storage cabinet
26. Telephone outlet
27. Nurses' call with emergency call button with duplex receptacle
28. 500-watt indirect lighting units
29. 200-watt semidirect lighting unit
30. Single receptacle 30 amps.
31. Glazed door
32. Hook strip
33. Shelf 48 inches above floor
34. Window sills approximately 6 feet above floor

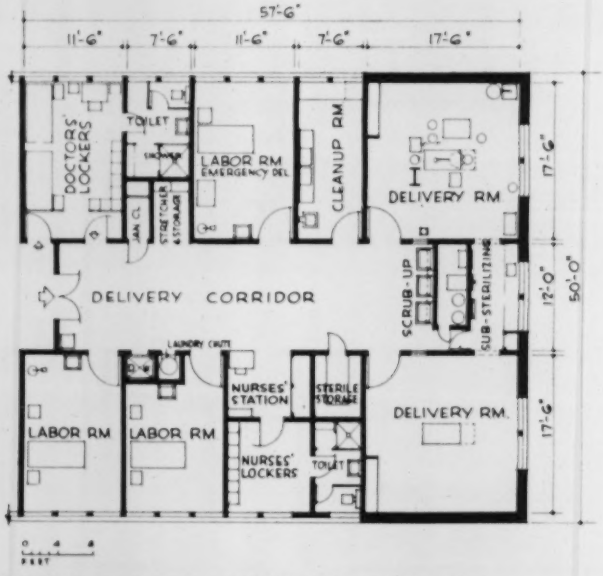


OBSTETRICS DEPARTMENT

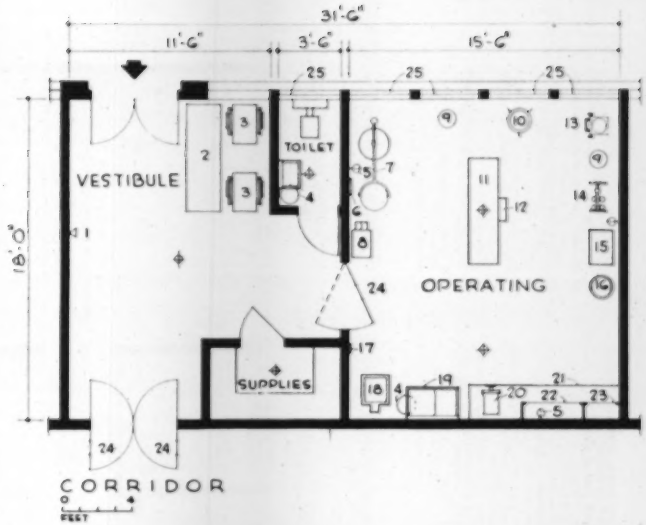


56—Delivery Suite for a 100-Bed General Hospital

1. Combination box spring and mattress on legs
2. Night table
3. Straight chair
4. Telephone outlet
5. Waste paper receptacle
6. Table
7. Recessed double x-ray film illuminator
8. Lockers
9. Bulletin board, 26 x 24 inches
10. Linen hamper
11. Wheel stretcher
12. Double compartment laundry tray with drainboards
13. Water cooler
14. Clinical sink with bedpan flushing attachment
15. Dome light and buzzer, set 5 feet 6 inches from floor
16. Counter 36 inches high, open below
17. Cabinet below counter, 2 feet wide
18. Sanitary waste receptacle
19. Vision panel
20. Adjustable open shelving, 18 inches wide
21. Clock with sweep second hand
22. Explosion proof outlet
23. Corridor dome light
24. Mercury switch
25. Single basin stand
26. Explosion proof calling station, foot operated
27. Aspirator
28. Heated bassinet
29. Adjustable stool
30. Portable emergency light
31. Anesthetists' table
32. Anesthetists' stool
33. Anesthesia unit
34. Instrument table
35. Kick bucket
36. Delivery table
37. Obstetrical light
38. Mayo table
39. Kick bucket
40. Flush ceiling fixture for general illumination
41. View window, clear glass
42. Scrub sink
43. Soap dispenser
44. Clock
45. Shelf over scrub sinks
46. High speed pressure sterilizer, 16 x 24 inches
47. Floor drain
48. Water sterilizers, 15 gallons each
49. Sink in counter
50. Wall cabinet set 42 inches from floor
51. Blanket and solution warmer
52. Lavatory with gooseneck spout and knee control
53. Examining light
54. Nurses' calling station with duplex receptacle
55. Bed light
56. Bedside cabinet
57. Obstetrical bed
58. Foot stool
59. Shelving
60. Dumbwaiter connecting with central sterilizing room
61. Labor bed



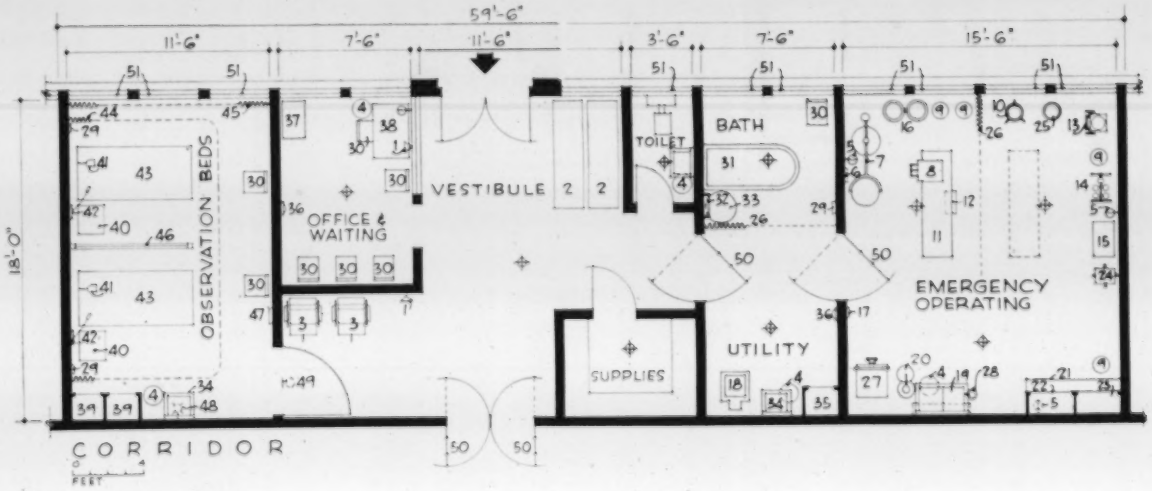
57—Delivery Suite for a 200-Bed General Hospital



58—*Small Emergency Suite*

1. Telephone outlet
2. Wheel stretcher
3. Wheel chair
4. Waste paper receptacle
5. Explosion proof outlet
6. Clock
7. Portable emergency light
8. Mayo table
9. Adjustable stool
10. Kick bucket
11. Examining table
12. Foot stool
13. Resuscitating apparatus
14. Anesthesia unit
15. Instrument table, 16 x 24 inches
16. Single basin stand
17. Mercury switch
18. Clinical sink with bed pan flushing attachment
19. Combination instrument and scrub sink with gooseneck spout and knee control
20. Pressure sterilizer, 8 x 16 inches, on counter
21. Counter, 36 inches high, with cabinets below
22. Wall cabinet
23. Locked wall cabinet with inner locked narcotic compartment and inside light
24. Vision panel
25. Obsure glass

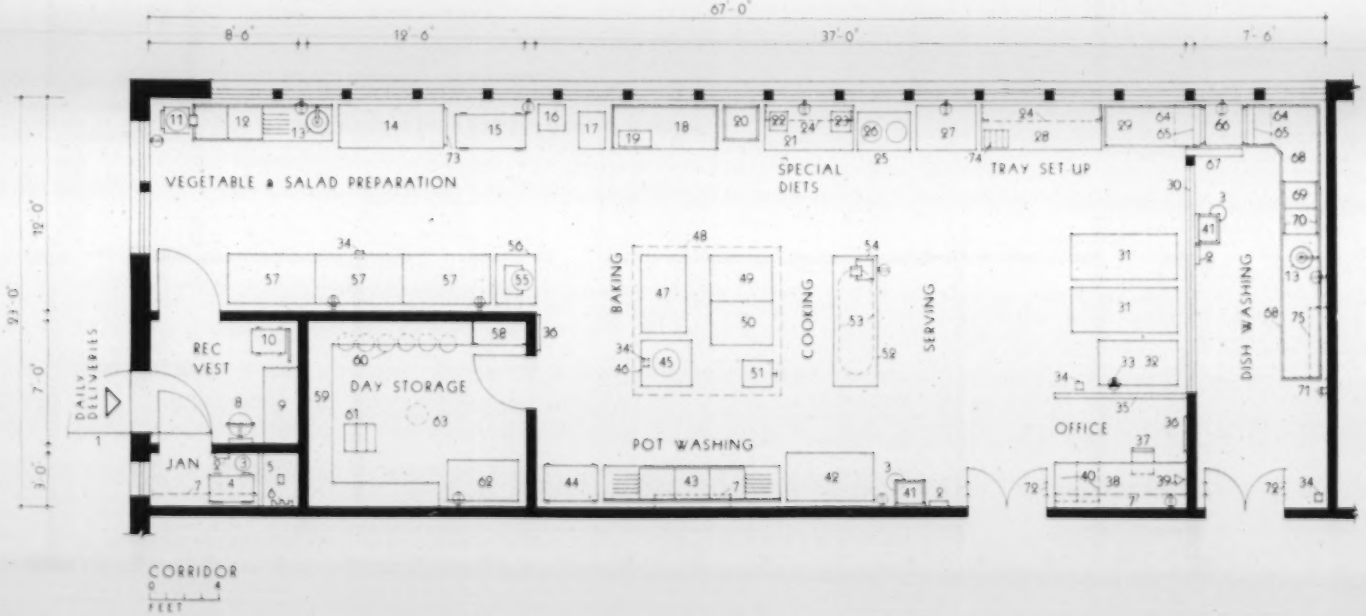
1. Telephone outlet
2. Wheel stretcher
3. Wheel chair
4. Waste paper receptacle
5. Explosion proof outlet
6. Clock
7. Portable emergency light
8. Mayo table
9. Adjustable stool
10. Kick bucket
11. Examining table
12. Foot stool
13. Resuscitating apparatus
14. Anesthesia unit
15. Instrument table, 16 x 24 inches
16. Double basin stand
17. Mercury switch
18. Clinical sink with bed pan flushing attachment
19. Combination instrument and scrub sink with gooseneck spout and knee control
20. Alcohol dispenser
21. Counter, 36 inches high, with cabinets below
22. Wall cabinet
23. Locked wall cabinet with inner locked narcotic compartment and inside light
24. Leg stand
25. Sanitary waste receptacle
26. Curtain and rod
27. High speed pressure sterilizer, 16 x 24 inches
28. Single soap dispenser
29. Hook strip
30. Straight chair
31. Shallow tub
32. Towel bar
33. Linen hamper
34. Lavatory with gooseneck spout and knee control
35. Blanket warmer
36. Dome light and buzzer, set 5 feet 6 inches from floor
37. Filing cabinet, letter size, 4 drawers
38. Desk
39. Locker
40. Bedside cabinet
41. Bed light
42. Nurses' calling station with duplex receptacle
43. Adjustable hospital bed
44. Cubicle curtain and rod
45. Sliding window curtain
46. Cubicle partition, 7 feet high with obscure glass in upper panels
47. Night light
48. Wall bracket light, switch controlled
49. Corridor dome light
50. Vision panel
51. Obscure glass



59—Large Emergency Suite

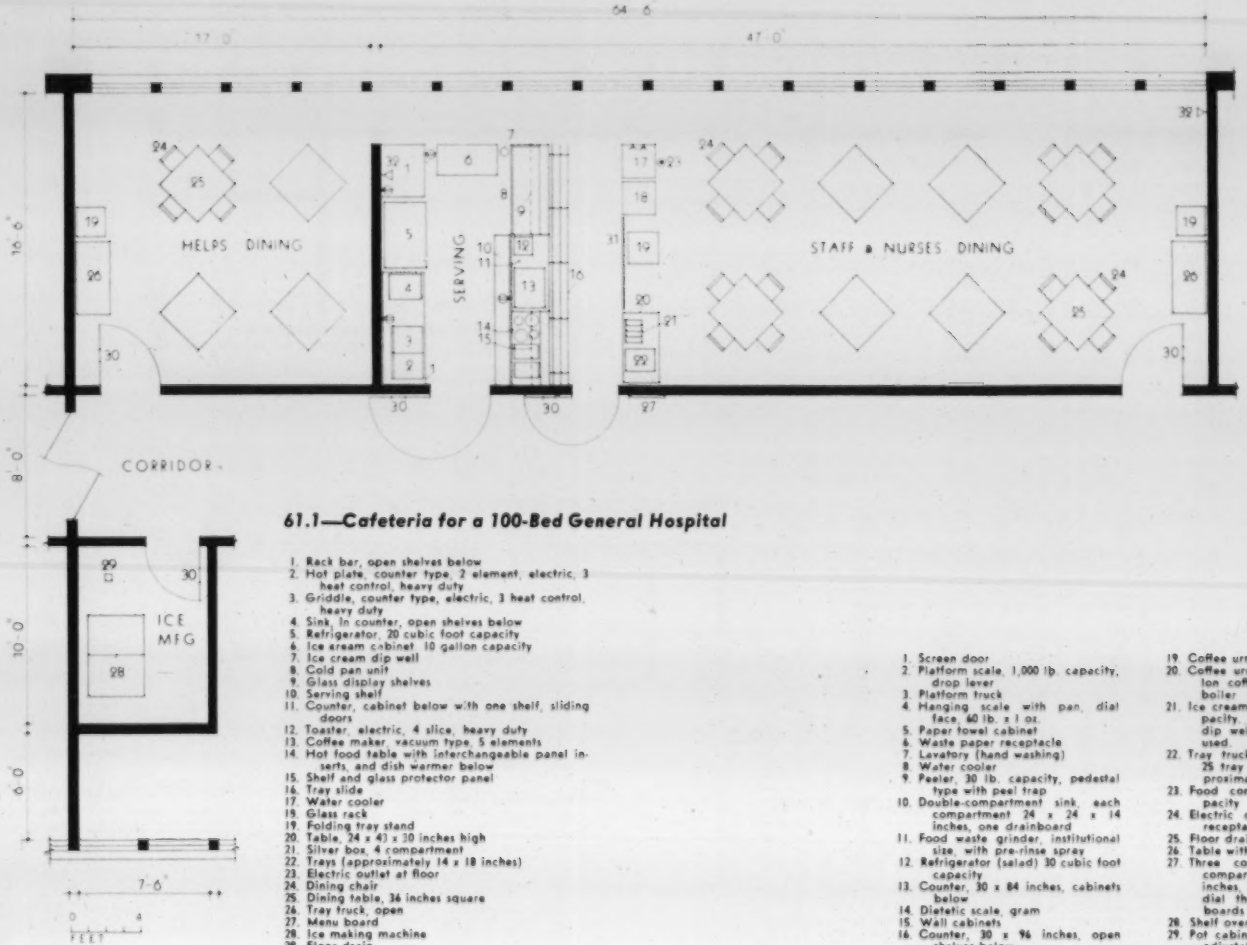
1. Screen door
2. Paper towel cabinet
3. Waste paper receptacle
4. Mop truck
5. Curb and receptor or sink
6. Mop rack
7. Shelf over
8. Hanging scale with pan, dial face, 60 lb. x 1 oz.
9. Counter, for checking deliveries
10. Platform scale
11. Peeler, 15 lb. capacity, pedestal type with peel trap
12. Double compartment sink, each compartment 24 x 24 x 14 inches, one drainboard
13. Food waste grinder, institutional size, with pre-rinse spray
14. Preparation table, 30 x 72 inches, with 2 drawers and undershelf
15. Utility truck
16. Water cooler
17. Cooling rack, 24 x 18 x 72 inches, on casters
18. Baker's table, 30 x 72 inches with 2 drawers and overshelf
19. Baker's scale
20. Single-compartment sink, 24 x 24 x 14 inches
21. Counter, 30 x 60 inches, cabinets below
22. Dietetic scale, gram
23. Toaster, electric, 4 slice, heavy duty
24. Wall cabinets
25. Coffee urn stand
26. Coffee urn (battery), one 5 gallon coffee urn, one 10 gallon boiler
27. Ice cream cabinet, 15 gallon capacity. Provide running water dip well if bulk ice cream is used.
28. Counter, 30 x 84 inches, open shelves below
29. Clean dish table with upturned edge
30. Glass partition above wainscot
31. Tray truck, open, approximately 25 tray capacity (tray size approximately 14 x 18 inches)
32. Food conveyor, 50 patient capacity
33. Electric outlet
34. Floor drain
35. Partition 3 feet high
36. Bulletin board, 26 x 24 inches
37. Straight chair
38. Built-in desk
39. Telephone outlet
40. File cabinet, 2 drawer
41. Lavatory, (hand washing)
42. Refrigerator (salad and cook's), 40 cubic foot capacity
43. Three-compartment sink, each compartment 24 x 24 x 14 inches, one compartment with dial thermometer, two drainboards
44. Pot cabinet, 24 x 36 x 72 inches, adjustable open shelving, on casters
45. Kettle, steam jacketed, 10 gallon capacity
46. Floor depression
47. Roasting oven, two sections, each with additional removable shelf for baking (deck 33 x 22 inches)
48. Hood
49. Range, oven below
50. Range, one-section griddle, and one-section hot top, broiler below
51. Steamer, one bushel capacity
52. Cook's table, 30 x 90 inches, with plate warmer section below
53. Pot rack, over cook's table
54. Meat slicer, motor driven
55. Mixer, bench type, 20 quart capacity with 12 quart bowl, meat and food chopper attachments
56. Cabinet stand for mixer
57. Refrigerator, 40 cubic foot capacity
58. Locked cabinet
59. Shelves, 16 inches deep, first shelf 36 inches from floor
60. Storage can, mounted on casters
61. Step ladder, pantry type
62. Frozen food cabinet, vertical type, 13 cubic foot capacity
63. Ventilator at ceiling
64. Hood
65. Dish table drain
66. Dishwashing machine, single tank, floor model, vertical sliding door, approximate capacity 1,250 pieces per hour, automatically timed
67. Rack return
68. Soiled dish table with 3 inch upturned edge
69. Double compartment soak sink
70. Slide rails (for conveying dish racks)
71. Hot and cold water outlet
72. Vision panel
73. Kitchen tool rack
74. Silver box, 4 compartment
75. Shelf over for soiled glasses

(NOTE: If food waste grinders are not used, garbage refrigerator and can washing room should be provided.)



60R—Kitchen for a 50-Bed General Hospital (Using Centralized Bulk Service)

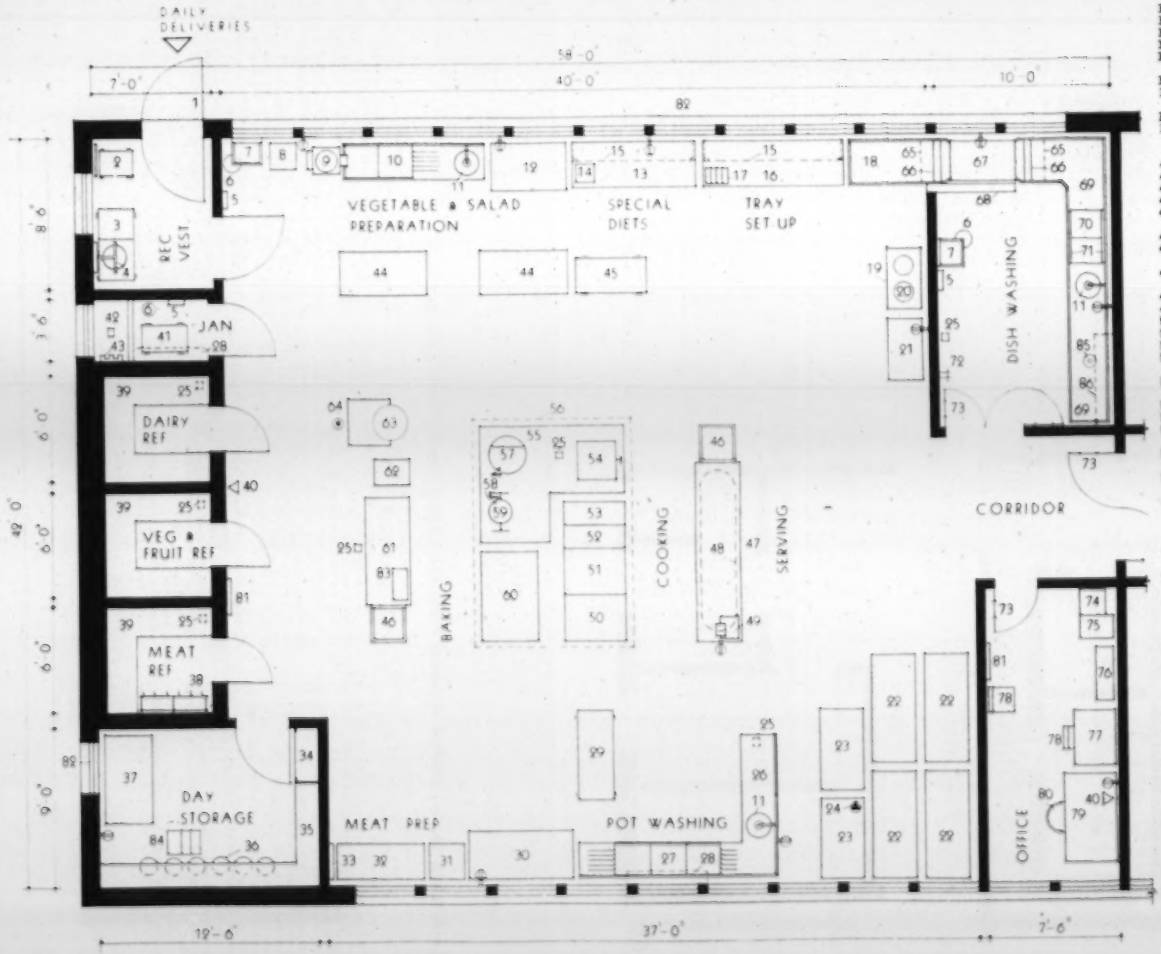
SERVICE DEPARTMENT



61.1—*Cafeteria for a 100-Bed General Hospital*

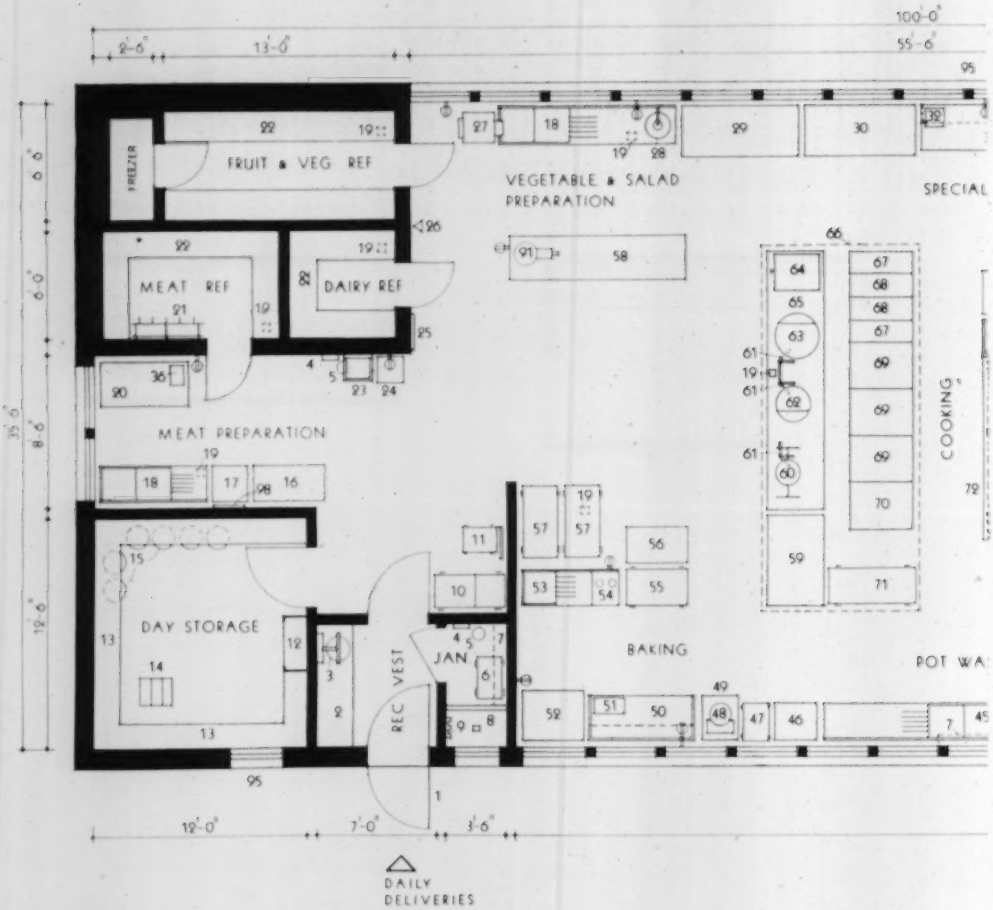
1. Rack bar, open shelves below
2. Hot plate, counter type, 2 element, electric, 3 heat control, heavy duty
3. Griddle, counter type, electric, 3 heat control, heavy duty
4. Sink, in counter, open shelves below
5. Refrigerator, 20 cubic foot capacity
6. Ice cream cabinet, 10 gallon capacity
7. Ice cream dip well
8. Cold pan unit
9. Glass display shelves
10. Serving shelf
11. Counter, cabinet below with one shelf, sliding doors
12. Toaster, electric, 4 slice, heavy duty
13. Coffee maker, vacuum type, 5 elements
14. Hot food table with interchangeable panel inserts, and dish warmer below
15. Shelf and glass protector panel
16. Tray slide
17. Water cooler
18. Glass rack
19. Folding tray stand
20. Table, 24 x 42 x 30 inches high
21. Silver box, 4 compartment
22. Trays (approximately 14 x 18 inches)
23. Electric outlet at floor
24. Dining chair
25. Dining table, 36 inches square
26. Tray truck, open
27. Menu board
28. Ice making machine
29. Floor drain
30. Vision panel
31. Railing
32. Telephone outlet

1. Screen door
2. Platform scale, 1,000 lb. capacity, drop lever
3. Platform truck
4. Hanging scale with pan, dial face, 60 lb. x 1 oz.
5. Paper towel cabinet
6. Waste paper receptacle
7. Lavatory (hand washing)
8. Water cooler
9. Peeler, 30 lb. capacity, pedestal type with peel trap
10. Double-compartment sink, each compartment 24 x 24 x 14 inches, one drainboard
11. Food waste grinder, institutional size, with pre-rinse spray
12. Refrigerator (salad) 30 cubic foot capacity
13. Counter, 30 x 84 inches, cabinets below
14. Dietetic scale, gram
15. Wall cabinets
16. Counter, 30 x 96 inches, open shelves below
17. Silver box, 4 compartments
18. Clean dish table with upturned edge
19. Coffee urn stand
20. Coffee urn (battery), one 5 gallon coffee urn, one 10 gallon boiler
21. Ice cream cabinet, 10 gallon capacity. Provide running water dip well if bulk ice cream is used.
22. Tray truck, open, approximately 25 tray capacity (Tray size approximately 14 x 18 inches)
23. Food conveyor, 50 patient capacity
24. Electric outlet, ceiling drop, 2 receptacles
25. Floor drain
26. Table with upturned edge
27. Three compartment sink, each compartment 24 x 24 x 14 inches, one compartment with dial thermometer, two drainboards
28. Shelf over
29. Pot cabinet, 24 x 60 x 72 inches, adjustable open shelving, on casters
30. Refrigerator (cook's) 50 cubic foot capacity



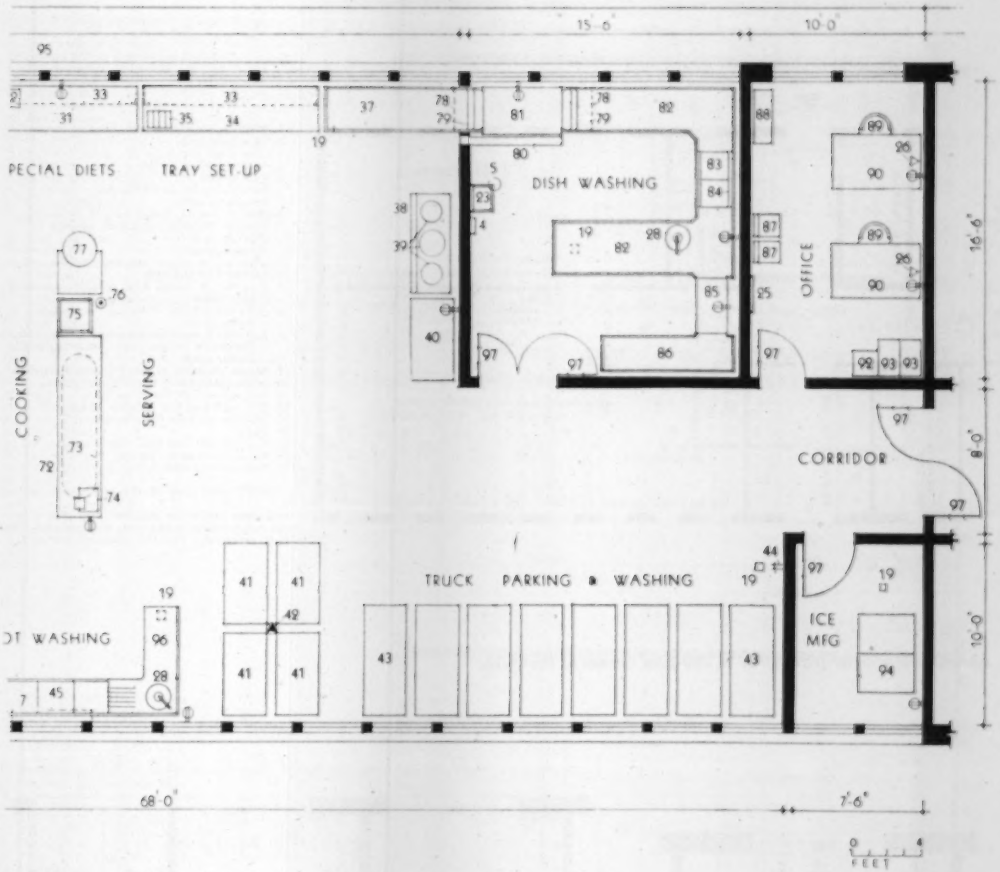
31. Meat block
32. Table, 24 x 60 inches
33. Kitchen tool rack
34. Locked cabinet
35. Shelves, 16 inches deep, first shelf 36 inches from floor
36. Storage can, mounted on casters
37. Frozen food cabinet, vertical type, 30 cubic foot capacity
38. Meat hooks and rail
39. Refrigerator shelving, 18 inches deep, first shelf 36 inches from floor
40. Telephone outlet
41. Mop truck
42. Curb and receptor or sink
43. Mop rack
44. Preparation table, 30 x 60 inches, with drawer and undershelf
45. Utility truck
46. Single compartment sink, 24 x 24 x 14 inches
47. Cook's table, 30 x 120 inches, with 2 drawers and undershelf
48. Pot rack over cook's table
49. Meat slicer, motor driven
50. Range, oven below
51. Range, broiler below
52. Spreader plate
53. Deep fat fryer, approximately 25 lb. capacity
54. Steamer, 2 compartment, 4 bu. capacity
55. Floor depression
56. Hood
57. Kettle, steam jacketed, 30 gallon capacity
58. Swinging water spout over steam kettle (hot and cold water)
59. Kettle, steam jacketed, trunnion, 10 gallon capacity
60. Roasting oven, two sections, each with additional removable shelf for baking (deck 42 x 32 inches)
61. Baker's table, 30 x 72 inches with 2 drawers and overshelf
62. Cooling rack, 24 x 18 x 72 inches, on casters
63. Mixer, 60 quart capacity, with 30 quart bowl, meat and food chopper attachments
64. Electric outlet at floor
65. Hood
66. Dish table drain
67. Dishwashing machine, single tank, floor model, vertical sliding door, approximate capacity 3,000 pieces per hour, automatic
68. Rack return
69. Soiled dish table with 3 inch upturned edge
70. Double compartment soak sink
71. Slide rails (for conveying dish racks)
72. Hot and cold water outlet
73. Vision panel
74. Locker
75. File cabinet
76. Bookcase
77. Table, 30 x 36 inches
78. Straight chair
79. Desk
80. Swivel chair with arms
81. Bulletin board, 26 x 24 inches
82. High windows
83. Baker's scale
84. Step ladder, pantry type
85. Glass washing brush
86. Shelf over for soiled glasses

61R—Kitchen for a 100-Bed General Hospital (Using Centralized Bulk Service)



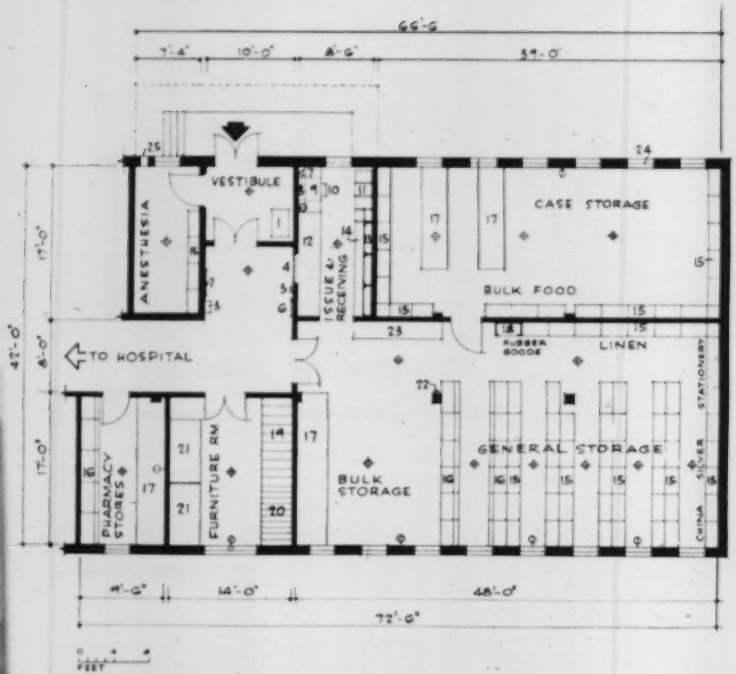
62R—Kitchen for a 200-Bed General Hospital (Using Centralized Bulk Service)

1. Screen door
2. Counter, for checking deliveries
3. Hanging scale with pan, dial face, 60 lb. x 1 oz.
4. Paper towel cabinet
5. Waste paper receptacle
6. Mop truck
7. Shelf over
8. Curb and receptor or sink
9. Mop rack
10. Platform truck
11. Platform scale, 1,000 lb. capacity, drop lever
12. Locked cabinet
13. Shelves, 16 inches deep, first shelf 36 inches from floor
14. Step ladder, pantry type
15. Storage can, mounted on casters
16. Table, 24 x 48 inches, on casters
17. Meat block
18. Double compartment sink, each compartment, 24 x 24 x 14 inches, one drainboard
19. Floor drain
20. Preparation table, 30 x 60 inches, with drawer and undershelf
21. Meat hooks and rail
22. Refrigerator shelving, 18 inches deep, first shelf 36 inches from floor
23. Lavatory (handwashing)
24. Water cooler
25. Bulletin board, 24 x 24 inches
26. Telephone outlet
27. Peeler, 30 lb. capacity, pedestal type with peel trap
28. Food waste grinder, institutional size, with pre-rinse spray
29. Refrigerator (salad), 60 cubic foot capacity
30. Refrigerator (cook's), 50 cubic foot capacity
31. Counter, 30 x 96 inches, cabinets below
32. Dietetic scale, gram
33. Wall cabinets
34. Counter, 30 x 120 inches, open shelves below
35. Silver box, 4 compartment
36. Meat chopper, 8 lb. per minute capacity
37. Clean dish table, with upturned edge
38. Coffee urn stand
39. Coffee urn (battery), two 5 gallon coffee urns, one 10 gallon boiler
40. Ice cream cabinet, 20 gallon capacity. Provide running water dip well if bulk ice cream is used
41. Food conveyor, 50 patient capacity
42. Electric outlet, ceiling drop, 4 receptacles
43. Tray truck, open, approximately 25 tray capacity (tray size approximately 14 x 18 inches)
44. Hot and cold water outlet
45. Three compartment sink, each compartment 24 x 24 x 14 inches, one compartment with dial thermometer, two drainboards
46. Proof box, 24 x 30 x 72 inches
47. Cooling rack, 24 x 18 x 72 inches
48. Mixer (bench type), 20 quart capacity, with 12 quart bowl



49. Cabinet stand for mixer
50. Baker's table, 30 x 72 inches, with two drawers and overshelf
51. Baker's scale
52. Refrigerator, 20 cubic foot capacity
53. Single compartment sink, 24 x 24 x 14 inches, one drainboard
54. Two-element hotplate flush with counter top (for baker)
55. Pot cabinet, 24 x 42 x 72 inches, adjustable open shelving, on casters
56. Counter, bread storage cabinet below
57. Utility truck
58. Preparation table, 30 x 120 inches, with drawer and undershelf
59. Oven, three sections, two sections baking, one section roasting with additional removable shelf (deck 42 x 32 inches)
60. Kettle, steam jacketed, trunnion, 10 gallon capacity
61. Swinging water spout over steam kettles (hot and cold water)
62. Kettle, steam jacketed, 30 gallon capacity
63. Kettle, steam jacketed, 60 gallon capacity
64. Steamer, three compartment, 6 bu. capacity
65. Floor depression
66. Hood
67. Spreader plate
68. Deep fat fryer, approximately 25 lb. capacity
69. Range, oven below
70. Broiler, double deck
71. Pot cabinet, 24 x 60 x 72 inches, adjustable open shelving, on casters
72. Cook's table, 30 x 120 inches, with 2 drawers and undershelf
73. Pot rack over cook's table
74. Meat slicer, motor driven
75. Single compartment sink, 24 x 24 x 14 inches
76. Electric outlet at floor
77. Mixer, 60 quart capacity, with 30 quart bowl
78. Hood
79. Dish table drain
80. Rack return
81. Dishwashing machine, single tank, approximate capacity 4,500 pieces per hour, automatic
82. Soiled dish table, with 3 inch upturned edge
83. Double compartment soak sink
84. Slide rails (for conveying dish racks)
85. Glass washing machine
86. Dish table with upturned edge (for clean glasses)
87. Straight chair
88. Bookcase
89. Swivel chair with arms
90. Desk
91. Food cutter, bowl 15 inches diameter
92. Locker
93. File cabinet
94. Ice making machine
95. High windows
96. Table with upturned edge
97. Vision panel
98. Kitchen tool rack

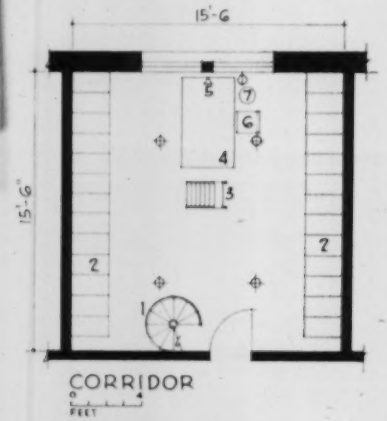
(NOTE: If food waste grinders are not used, garbage refrigerator and can washing room should be provided.)



1. Platform scale flush with floor
2. Time card rack
3. Time clock
4. Rolling curtain
5. Push button
6. Bulletin board, 24 x 24 inches
7. Telephone outlet
8. Shelf
9. Counter, 30 inches high with drawers
10. Straight chair
11. Filing cabinet
12. Counter, 42 inches high, open below
13. Locked wall cabinets
14. Counter, 36 inches high with locked cabinets below
15. Adjustable steel shelving, open type, 18 inches deep
16. Adjustable steel shelving with backs, upper shelves 18 inches deep, lower shelves 24 inches deep
17. Wood platform raised 8 inches from floor
18. Steel cabinet with shelving and doors
19. Bed spring bins for 10 springs
20. Bed head and foot bins for 10 sets
21. Mattress rack for 5 mattresses
22. Buzzer
23. Counter with one shelf below
24. All windows to be barred
25. Vent at floor level

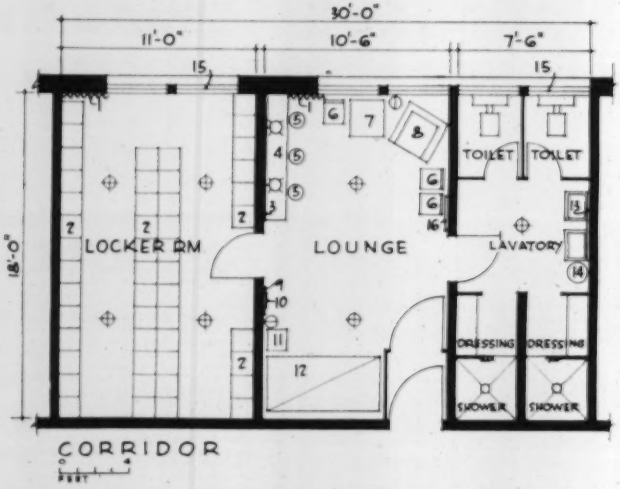
(NOTE: The size of the central storeroom and proportions of its various units will vary with each individual hospital. This plan shows the relationship of the units and generally the type of storage facilities required for each.)

63—Central Storeroom for a 100-Bed General Hospital



64—Record Storage for a 100-Bed General Hospital

1. Spiral stairway up to record room
2. Transfer files
3. Step ladder
4. Work table, 36 x 60 inches
5. Telephone outlet
6. Straight chair
7. Waste paper receptacle

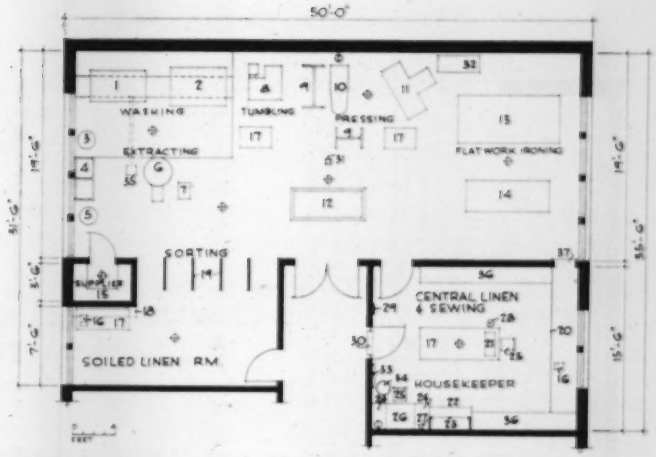


65—Nurses' Locker Room for a 100-Bed General Hospital

1. Sliding window curtain
2. Lockers, 15 x 15 x 60 inches
3. Mirror, 84 x 24 inches, above counter
4. Counter, 30 inches high, open below
5. Stool, 18 inches high
6. Straight chair
7. Lamp table
8. Easy chair
9. Full length mirror
10. Clock
11. End table
12. Combination box spring and mattress with legs
13. Mirrors over lavatories
14. Waste paper receptacle
15. Obscure glass
16. Bulletin board, 24 x 24 inches

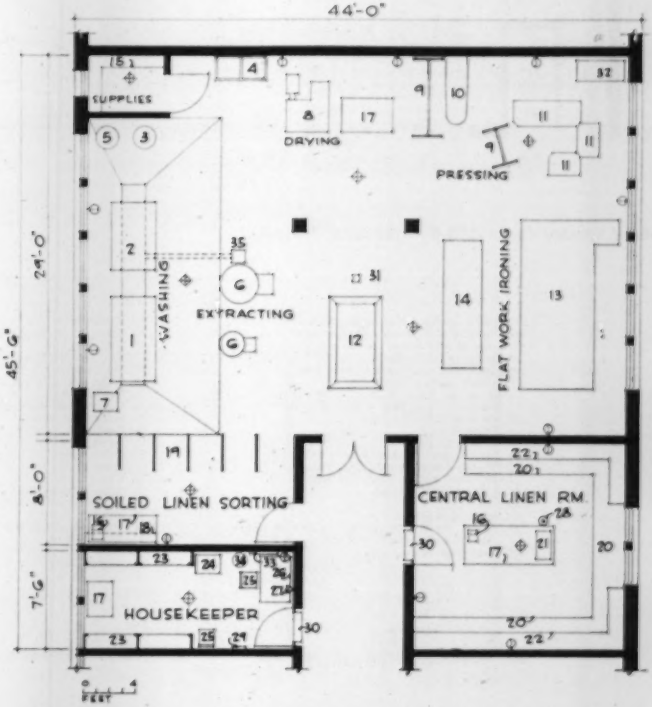
(NOTE: Female help locker room is similar.)

1. Metal washer, 25 lb. or 35 lb., open end
2. Metal washer, 30 x 48 inches
3. Soap tank, 30 gallons
4. Double compartment laundry trays
5. Starch cooker, 15 gallons
6. Extractor, 30 inches
7. Platform scale
8. Tumbler, 36 x 30 inches
9. Uniform rack
10. Ironing board
11. Press, 51 inches
12. Shakeout table with sloping sides
13. Flat work ironer, 2 roll, 100 or 110 inches
14. Table, 36 x 96 inches
15. Shelving
16. Marking machine
17. Tables, 2—24 x 36 inches, 1—24 x 60 inches, 1—36 x 90 inches
18. Shelf over table
19. Sorting bins
20. Counter, 36 inches high, with shelving below
21. Sewing machine
22. Counter, 30 inches high, with cabinets below
23. Wall cabinet
24. Filing cabinets below counter
25. Straight chair
26. Counter, 30 inches high, open below with drawers
27. Telephone outlet
28. Floor outlet
29. Hook strip
30. Dutch door
31. Floor drain
32. Compressor
33. Bulletin board, 26 x 24 inches
34. Waste paper receptacle
35. Sump
36. Shelving with bins
37. Pass window

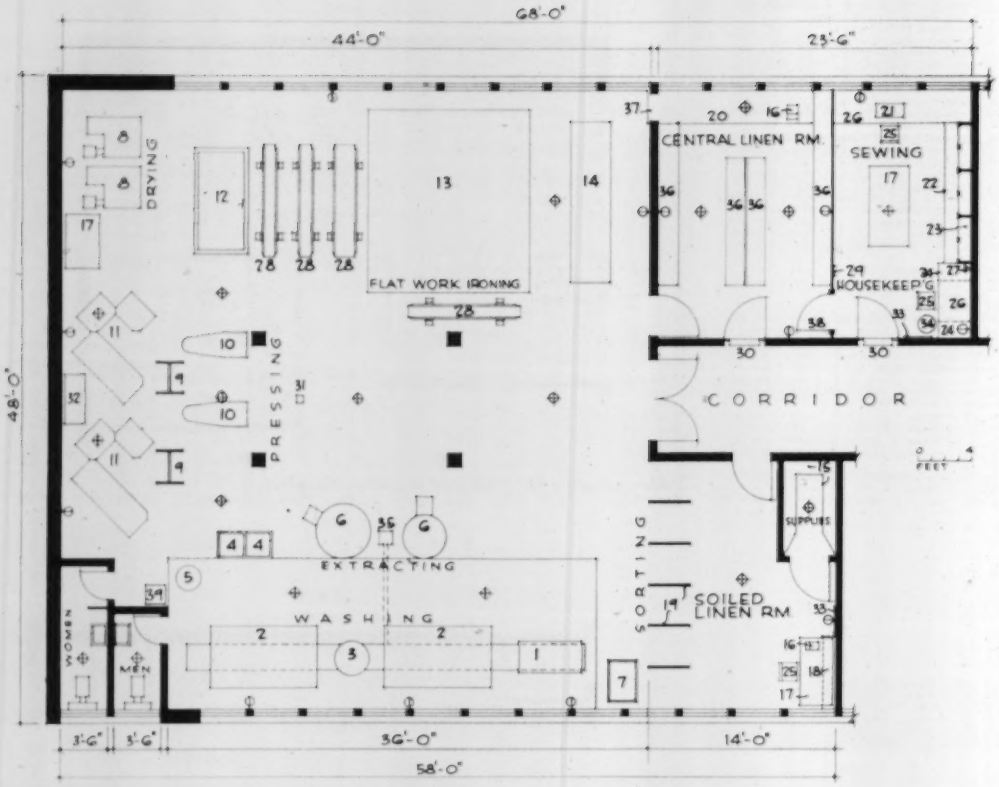


66—Laundry for a 50-Bed General Hospital

1. Metal washer, 42 x 54 inches
2. Metal washer, 30 x 30 inches
3. Soap tank, 60 gallons
4. Double compartment laundry trays
5. Starch cooker, 15 gals.
6. Extractor, 1—20 inch, and 1—30 inch
7. Platform scale
8. Tumbler, 36 x 30 inches
9. Uniform rack
10. Ironing board
11. One 51 inch and two mushroom presses
12. Shakeout table with sloping sides
13. Flat work ironer, 2 roll, 110 or 120 inches
14. Table, 36 x 120 inches
15. Shelving
16. Marking machine
17. Tables, 1—24 x 30 inches, 1—24 x 64 inches, 1—36 x 84 inches, 1—32 x 48 inches
18. Shelf over table
19. Sorting bins
20. Counter, 36 inches high, with shelving below
21. Sewing machine
22. Shelving with bins
23. Wall cabinet
24. Filing cabinet
25. Straight chair
26. Desk
27. Telephone outlet
28. Floor outlet
29. Hook strip
30. Dutch door
31. Floor drain
32. Compressor
33. Bulletin board, 26 x 24 inches
34. Waste paper receptacle
35. Sump

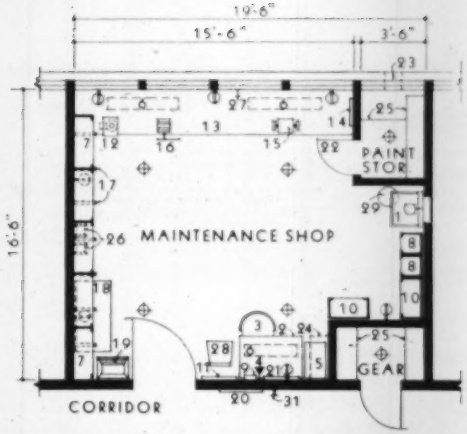


67—Laundry for a 100-Bed General Hospital



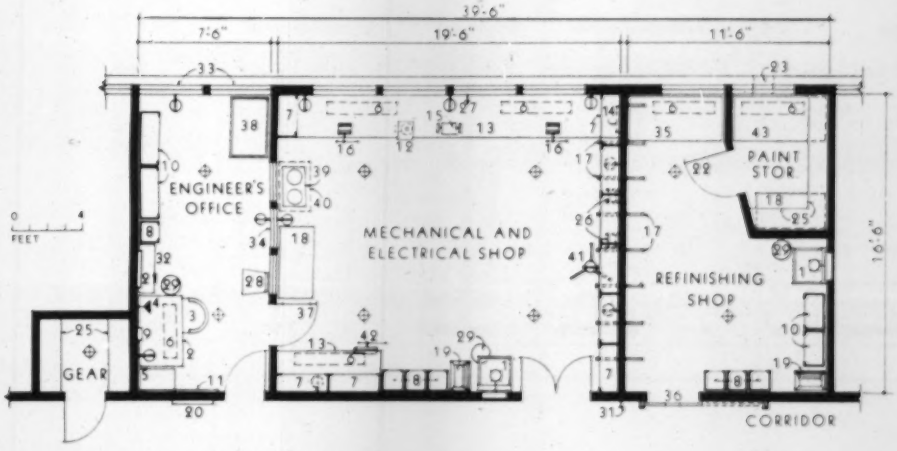
68—Laundry for a 200-Bed General Hospital

1. Metal washer, 35 or 50 lb., open end
2. Metal washer, 1—42 x 54 inches and 1—42 x 72 inches
3. Soap tank, 90 gallons
4. Double compartment laundry trays
5. Starch cooker, 25 gallons
6. Extractor, 1—30 inches, 1—40 inches
7. Platform scale, flush with floor
8. Tumbler, 36 x 30 inches
9. Uniform rack
10. Ironing board
11. Two 51 inch and 4 mushroom presses
12. Shakeout table with sloping sides
13. Flat work ironer, 4 roll, 120 inches
14. Table, 36 x 144 inches
15. Shelving
16. Marking machine
17. Tables, 1—30 x 60 inches, 1—30 x 48 inches, 1—36 x 72 inches
18. Shelf over table
19. Sorting bins
20. Counter, 36 inches high, with shelving below
21. Sewing machine
22. Counter, 30 inches high, with cabinets below
23. Wall cabinet
24. Filing cabinets below counter
25. Straight chair
26. Counter, 30 inches high, open below with drawer
27. Telephone outlet
28. Feed rack
29. Hook strip
30. Dutch door
31. Floor drain
32. Compressor
33. Bulletin board, 26 x 24 inches
34. Waste paper receptacle
35. Sump
36. Shelving with bins
37. Pass window
38. Gate
39. Water cooler



68.1—*Maintenance Shop for a 50-Bed General Hospital*

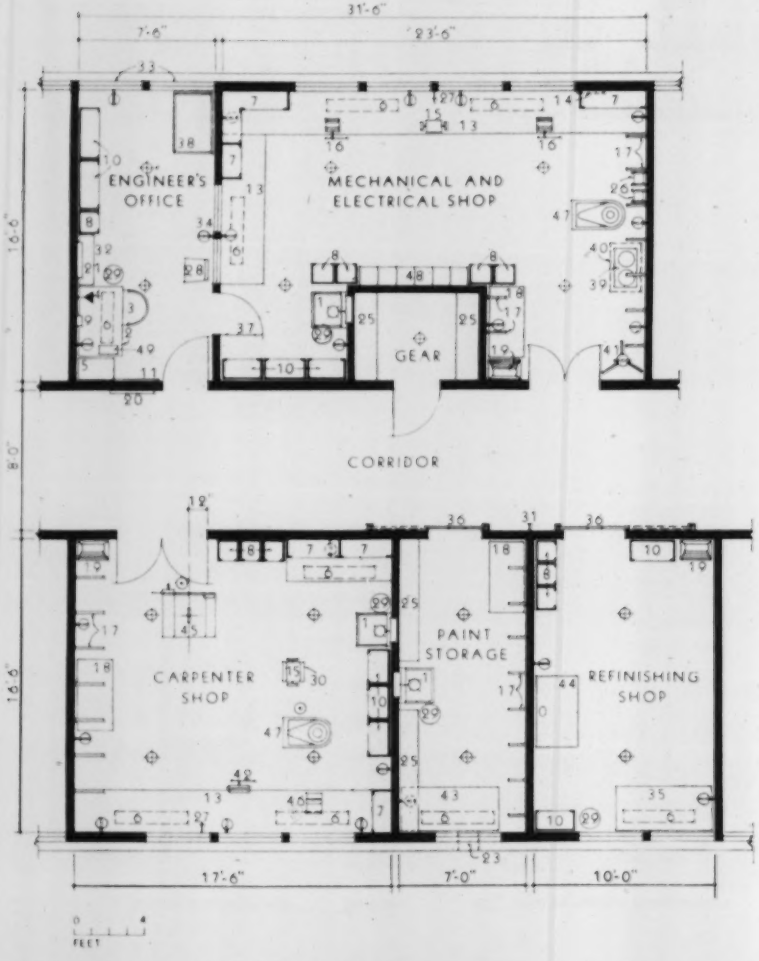
1. Service sink with grease trap, and medicine cabinet above
2. Desk
3. Desk chair
4. Telephone outlet
5. Legal size, 4 drawer filing cabinet
6. Fluorescent light, 7 feet above floor
7. Wall cabinet
8. Steel clothes locker, 15 x 15 x 60 inches
9. Master clock
10. Steel cabinet with shelving and doors
11. Bulletin board, 26 x 30 inches
12. Frame for portable drill press
13. Work bench, 36 inches high with heavy plant top, slide drawers and cabinets below
14. Test board with lamp and bell transformer
15. Electric buffer and grinder
16. Machinist's bench vise
17. Wall racks
18. Four wheel truck especially equipped for each shop
19. Step ladder, 8 feet high
20. Fire alarm board
21. Heating and ventilating control board
22. Automatic closing, metal covered fire door
23. Wall vents at floor and ceiling
24. Book shelf
25. Steel shelving
26. Extension cord reel, attached to wall
27. Compressed air outlet
28. Straight chair
29. Waste paper receptacle
30. Pedestal stand
31. Watchman's station
32. Sectional bookcase
33. Window blinds
34. Clear glass, beginning 40 inches above floor
35. Glass cutting table, 30 x 64 x 36 inches high with glass rack below
36. Automatic closing, metal covered sliding door with glass view panel
37. Door with upper panel of clear glass
38. Plan rack, 26 x 42 x 50 inches high, open top and bottom
39. Portable welding outfit
40. Portable ventilator hood
41. Portable pipe vise
42. Woodworker's vise
43. Work table, 30 x 64 x 36 inches high
44. Vapor tight spray hood with exhaust fan and hinged panels front and sides
45. Electric rip saw and jointer combination, 10-inch diameter
46. Key cutter
47. Drill press
48. Steel storage bins
49. Intercommunication, remote station



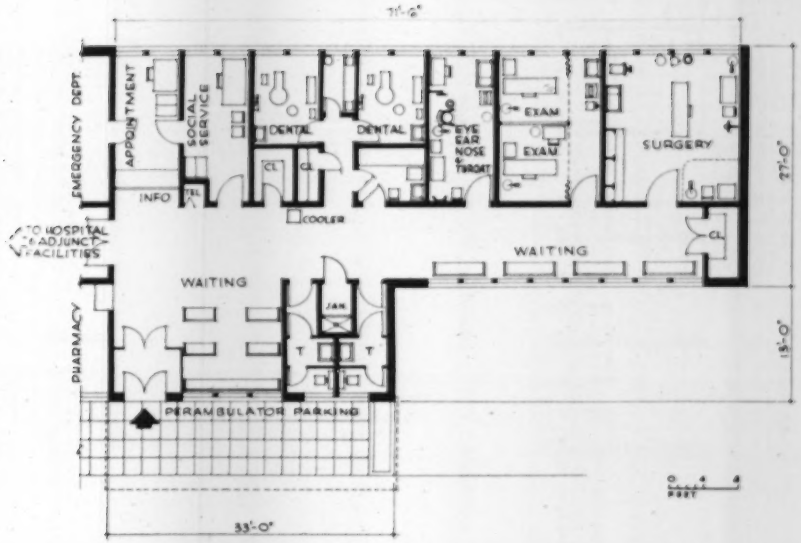
68.2—*Maintenance Shop for a 100-Bed General Hospital*

SERVICE DEPARTMENT

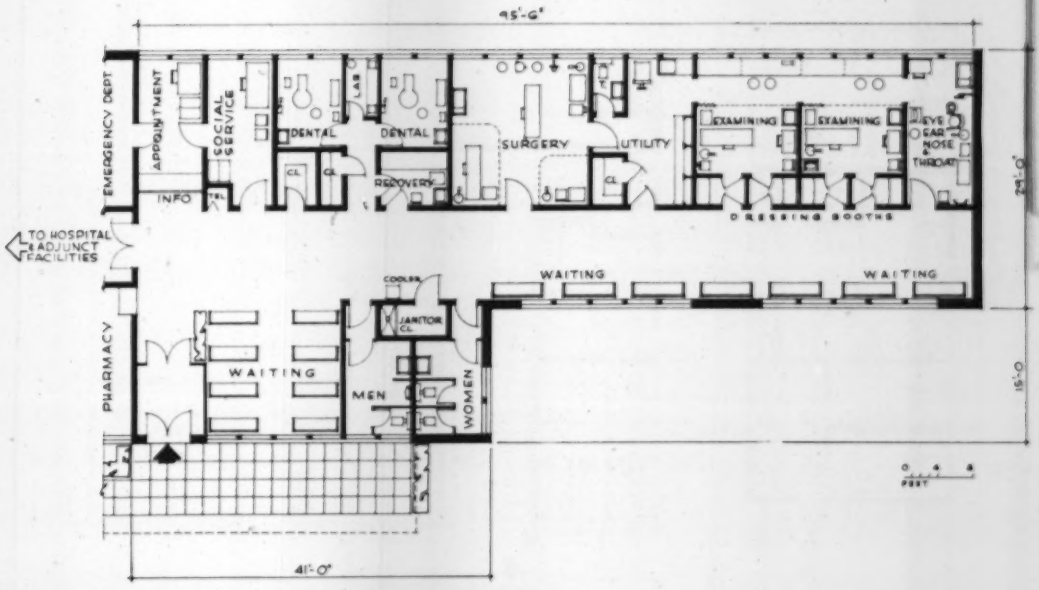
1. Service sink with grease trap, and medicine cabinet above
2. Desk
3. Desk chair
4. Telephone outlet
5. Legal size, 4 drawer filing cabinet
6. Fluorescent light, 7 feet above floor
7. Wall cabinet
8. Steel clothes locker, 15 x 15 x 60 inches
9. Master clock
10. Steel cabinet with shelving and doors
11. Bulletin board, 24 x 30 inches
12. Frame for portable drill press
13. Work bench, 36 inches high with heavy plant top, slide drawers and cabinets below
14. Test board with lamp and bell transformer
15. Electric buffer and grinder
16. Machinist's bench vise
17. Wall racks
18. Four wheel truck especially equipped for each shop
19. Step ladder, 8 feet high
20. Fire alarm board
21. Heating and ventilating control board
22. Automatic closing, metal covered fire door
23. Wall vents at floor and ceiling
24. Book shelf
25. Steel shelving
26. Extension cord reel, attached to wall
27. Compressed air outlet
28. Straight chair
29. Waste paper receptacle
30. Pedestal stand
31. Watchman's station
32. Sectional bookcase
33. Window blinds
34. Clear glass, beginning 40 inches above floor
35. Glass cutting table, 30 x 64 x 36 inches high with glass rack below
36. Automatic closing, metal covered sliding door with glass view panel
37. Door with upper panel of clear glass
38. Plan rack, 26 x 42 x 50 inches high, open top and bottom
39. Portable welding outfit
40. Portable ventilator hood
41. Portable pipe vise
42. Woodworker's vise
43. Work table, 30 x 64 x 36 inches high
44. Vapor tight spray hood with exhaust fan and hinged panels front and sides
45. Electric rip saw and jointer combination, 10-inch diameter
46. Key cutter
47. Drill press
48. Steel storage bins
49. Intercommunication, remote station



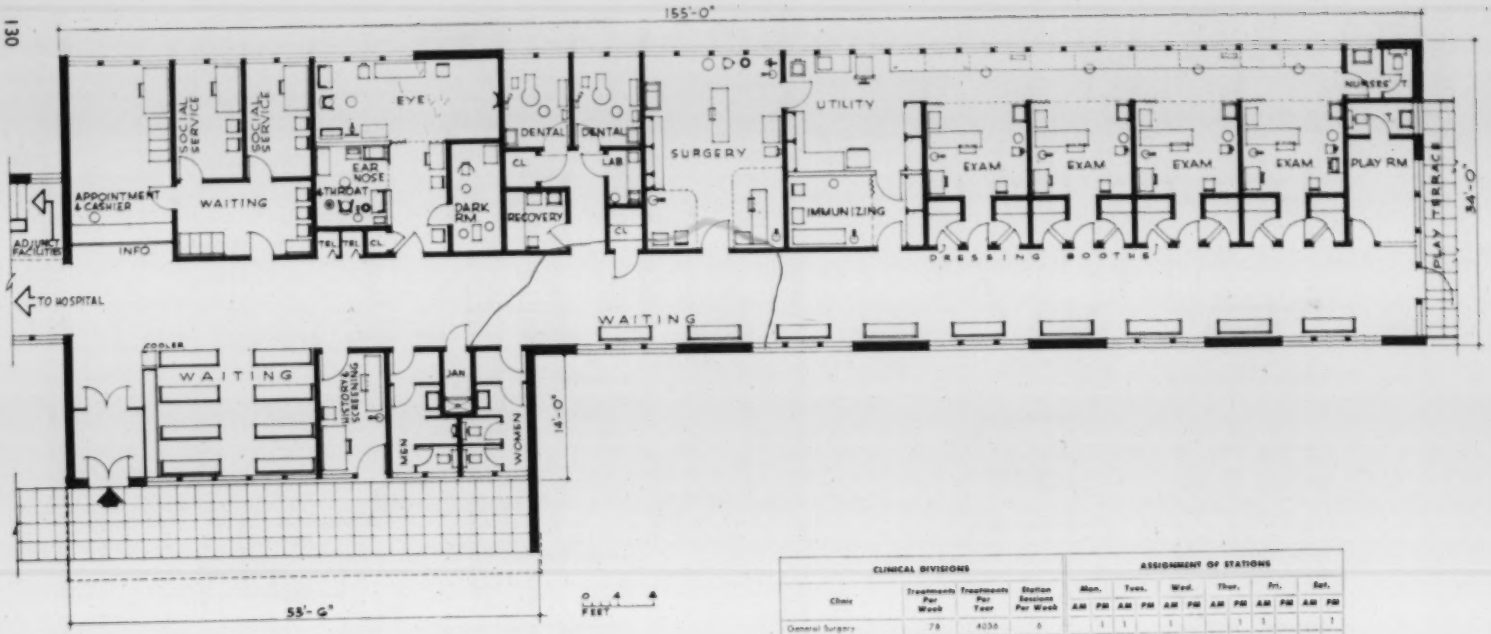
68.3—Maintenance Shop for a 200-Bed General Hospital



69—Outpatient Department for a 50-Bed General Hospital



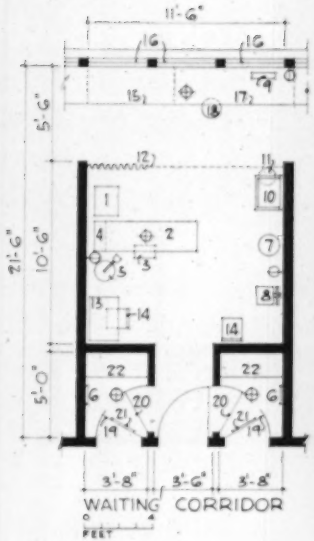
70—Outpatient Department for a 100-Bed General Hospital



71—Outpatient Department for a 200-Bed General Hospital

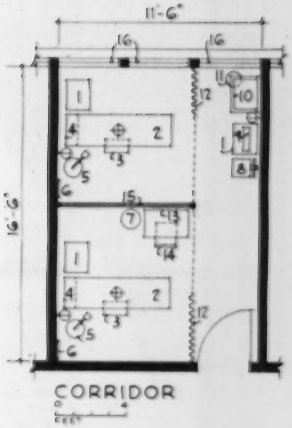
CLINICAL DIVISIONS				ASSIGNMENT OF STATIONS											
				Mon.		Tues.		Wed.		Thur.		Fri.		Sat.	
Clinic	Treatments Per Week	Treatments Per Year	Station Sessions Per Week	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
General Surgery	78	4056	6		1	1		1			1	1			1
Proctology	3	156	1		1										
Urology	11	572													
Dental	56	2912	6		2						2			2	
Gynecology	23	1196	2	1				1							
Obstetric	20	1040	2	1							1				
Orthopedic	28	1456	2			1									1
Eye	31	1612	2	1						1					
Ear, Nose & Throat	37	1924	3			1				1					1
General Medicine	102	5304	11	1		2		2		2		2		2	
Neuro Psychiatry	9	468	1							1					
Pediatric	43	2236	3		1						1	1		1	1
Dermatology & Syphilology	29	1508	3				1		1				1		
Physical Therapy	12	624	2	1											1
Totals	482	25,064	46	5	5	5	1	4	1	5	5	4	1	5	5

Possible Clinic Use Schedule—Based on Analysis of Clinic Load



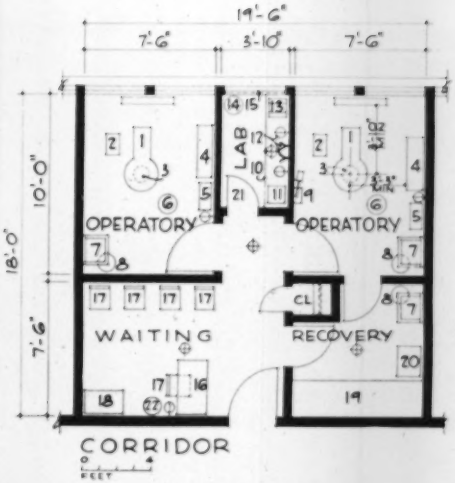
1. Table, 16 x 20 inches
2. Examining table
3. Footstool
4. Paper sheet dispenser
5. Examining light
6. Hook strip
7. Adjustable stool
8. Adult scale
9. Instrument sterilizer, 4 x 6 x 16 inches
10. Lavatory with gooseneck spout and knee or elbow control
11. Waste paper receptacle
12. Cubicle curtain and rod
13. Table 20 x 30 inches
14. Straight chair
15. Counter, 36 inches high with cabinets below
16. Obscure glass
17. Counter, 36 inches high, open below
18. Stool
19. Door, spring latch and with throw bolt on dressing room side
20. Door, spring latch
21. Mirror
22. Built in seat

72—Examination and Treatment Room with Dressing Cubicles



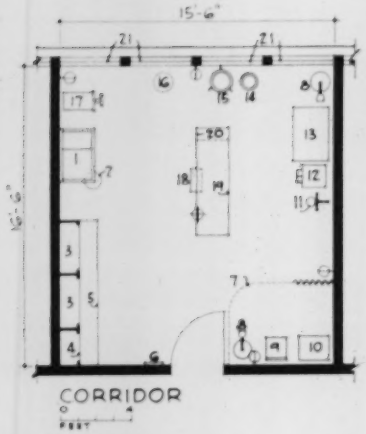
73—Examination and Treatment Room

1. Table, 16 x 20 inches
2. Examining table
3. Footstool
4. Paper sheet dispenser
5. Examining light
6. Hook strip
7. Adjustable stool
8. Adult scale
9. Instrument sterilizer, 4 x 6 x 16 inches
10. Lavatory with gooseneck spout and knee or elbow control
11. Waste paper receptacle
12. Cubicle curtain and rod
13. Table, 18 x 30 inches
14. Straight chair
15. Partition with obscure glass in upper panel
16. Obscure glass



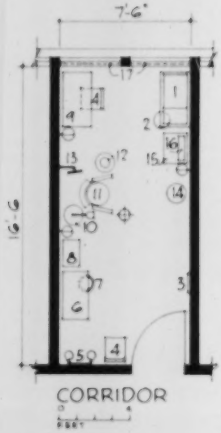
1. Dental chair
2. Dental unit
3. Dental operating light
4. Dental instrument cabinet
5. Instrument sterilizer, 4 x 6 x 16 inches, on stand
6. Adjustable stool
7. Lavatory with gooseneck spout and knee control
8. Towel receptacle
9. Dental x-ray, wall model
10. Laboratory counter, 36 inches high with cabinets below
11. Sink in counter
12. Gas, air and electric outlets
13. Developing tank
14. Compressor
15. Light proof shade
16. Desk, 20 x 36 inches
17. Straight chair
18. Filing cabinet
19. Built in couch
20. Bedside table, 16 x 20 inches
21. Light proof door with louvre
22. Waste paper receptacle

74—Dental Suite with Two Operating Rooms



75—Surgical Room

1. Combination instrument and scrub sink with gooseneck spout and spray and knee control
2. Waste paper receptacle
3. Wall cabinet
4. Locked wall cabinet with inner locked narcotic compartment and inside light
5. Counter, 36 inches high, with cabinets below
6. Hook strip
7. Cubicle curtain and rod
8. Examining light
9. Straight chair
10. Table
11. Irrigator stand
12. Mayo table
13. Instrument table
14. Sanitary waste receptacle
15. Kick bucket
16. Adjustable stool
17. Pressure sterilizer, 8 x 16 inches, on stand
18. Footstool
19. Examining table
20. Paper sheet dispenser
21. Obscure glass



1. Combination instrument and scrub sink with gooseneck spout and spray and knee control
2. Waste paper receptacle
3. Hook strip
4. Straight chair
5. Illuminated test card cabinet
6. Table, 18 x 33 inches
7. Sanitary waste receptacle
8. Compressed air and vacuum apparatus
9. Table, 20 x 36 inches
10. Examining light
11. Specialist chair
12. Fountain cuspidor
13. Adjustable eye range mirrror
14. Adustable stool
15. Table, 16 x 20 inches
16. Instrument sterilizer, 4 x 6 x 16 inches
17. Lightproof shades

75.1—Eye, Ear, Nose and Throat Room for a Small Outpatient Department

76—Eye, Ear, Nose and Throat Room for a 200-Bed General Hospital

1. Specialist's chair
2. Adjustable stool
3. Treatment table
4. Supply cabinet
5. Examining spot light
6. Trial lens case
7. Mayo table
8. Examining table
9. Straight chair
10. Illuminated test card cabinet
11. Table, 20 x 36 inches
12. Table for transillumination equipment
13. Perimeter
14. Slit lamp
15. Combination instrument and scrub sink with goose neck spout and knee control
16. Waste paper receptacle
17. Instrument sterilizer, 4 x 6 x 16 inches
18. Compressed air and vacuum apparatus
19. Fountain cuspidor
20. Sanitary waste receptacle
21. Examining light
22. Hook strip
23. Sliding curtain
24. Partition, 6 feet high
25. Shades or venetian blinds
26. Table, 16 x 20 inches

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Pyridoxine Hydrochloride	3 mg.
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*MDR—Minimum Daily Requirement
†RDA—Recommended Daily Dietary Allowance

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The preservation of x-ray films —five pertinent reasons

CHARLES U. LETOURNEAU, M.D.

HOW LONG should x-ray films be kept? This question is causing a current headache among hospital administrators and heads of radiology departments. With the increasing value of hospital cubic space, some good reasons must be found for keeping these bulky records or they should be disposed of. The problem is not new. Twenty years ago, there was much controversy over the value of preserving x-ray films. In those days, there was another good reason for getting rid of them besides their appetite for space. Made of cellulose nitrate (celluloid) they were a fire hazard and had been responsible for more than a few deaths. The cellulose acetate film had not yet been developed to its present high standard of accuracy. Today, however, safety film has eliminated danger from fire as a valid reason for disposing of old x-rays. There is but one good argument against preservation of x-ray films, and that is cost of storage space.

There is no law that obliges a hospital to preserve x-ray films for any given period of time. Nor has there been any official pronouncement by any body in the medical or associated fields on the preservation of x-ray films. The American Hospital Association has passed a resolution recommending that medical records be kept for a period of 25 years. Although the rule was mainly directed toward the written record, it would seem to be applicable to x-ray films since they are, by their very nature, records of the patient's condition at a certain time of his life. Even if this interpretation is wrong, there are five good reasons why x-ray films should be kept indefinitely.

Dr. Letourneau is secretary of the Council on Professional Practice.

HEALTH OF THE PATIENT

The most important reason for preserving the x-ray film is its use in the future care of the patient. To destroy the original x-ray film and to rely entirely on the report of the radiologist is to reduce by that much the patient's chances of getting an accurate diagnosis. To mention but one area where the x-ray film is important, consider the question of tuberculosis.

Radiologists will admit honestly that the early lesion of tuberculosis can be missed easily. Especially is this true on a routine chest film. Subsequent chest films, taken years later, may reveal a questionable shadow and many a diagnosis has been made by comparison with original chest films. Without the old films for comparison, it is possible that an ill-defined shadow may be dismissed as inconsequential. More than one patient has been saved a major stomach operation because comparison made with old films revealed that an ulcer was either quiescent or regressing under medical treatment.

In urology it is frequently possible to avoid a cystoscopy by proving that a shadow suspicious of a stone in the ureter was there years before and is probably a phlebolite. To trace the developments of rickets from the infant to adult life requires access to old films. There are many progressive disease conditions that require comparison with old x-ray films to determine the rate at which the disease is improving or getting worse under treatment.

Even x-ray films that purport to show nothing but a normal portion of the anatomy may contain some undetected disease in its incipient stages. Radiologists are not infallible and early lesions are frequently missed.

TEACHING AND RESEARCH

All too little research has been done on hereditary and congenital diseases and abnormalities. The x-ray film offers an excellent medium for comparison of bony and anatomical formations of entire families. The film that shows so little in the way of pathological changes may later turn out to be an important item in a research project. X-ray films are also of inestimable benefit in the study of the processes of growth and deterioration of the human body. Much remains to be learned in this particular field. The modern practice of annual chest x-rays may yield much information by comparison of chest plates from year to year.

As a teaching aid, the x-ray film speaks for itself. The development of any particular lesion may be traced from its inception to autopsy. Combined with the actual anatomy, either living or dead, the x-ray film is a graphic demonstration that is not easily forgotten. Films of unusual conditions can be preserved indefinitely for demonstration to students and physicians. A good collection of teaching films of any particular disease is worth many hours of illustrationless lecturing, even by the most facile speaker.

RIGHTS OF THE PATIENT

Another reason for preserving film is for the patient's welfare. The preservation of the x-ray film is a protection of his civil rights in a law court. The x-ray film itself is the best evidence that the patient can present to prove the truth of his allegations. The report of the radiologist, no matter how well or how carefully made, is not as valuable as the actual film itself. The maxim "one picture is worth 10,000 words," is as valid today as it ever was. Even if the radiologist who made the report

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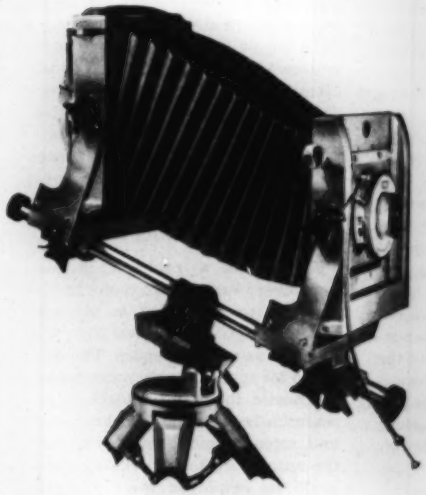

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is available to testify, it would be an almost superhuman feat of recollection for him to remember the details of one of thousands of films which he examined years before. Cross-examination by an attorney would be almost impossible.

On the other hand, it is extremely difficult to alter a film without detection. Its authenticity is therefore easy to establish. A report can be changed or substituted, but the x-ray film does not lend itself easily to such chicanery. To destroy the x-ray film of the patient's condition is to deprive him of his best chance of obtaining justice before the law.

Some may contend that x-ray films should be kept only as long as the statute of limitations preserves the right of action. Up to a point this is correct, but it must always be remembered that the statute of limitations does not begin to run until the damage has been discovered, and the damage may not be discovered for several years. It should also be recalled that the statute of limitations does not operate against minors and only begins to run when they come of legal age. X-ray films of children should be preserved indefinitely.

THE HOSPITAL AND THE PHYSICIAN

In addition to the patient, two other parties are concerned in the preservation of x-ray records, namely, the hospital and the physicians who were involved in the care of the patient. In an action for damages by a patient against a hospital or its radiologist, for example, the radiologist's unsupported testimony on his own or the hospital's behalf cannot be expected to carry much weight with an impartial jury. When the x-ray film is presented in court the evidence, properly identified, is there for all to see. It is open to inspection by experts appointed by the court or by either of the litigants. Though the jury may be confused by medical language, it can be made to understand the meaning of certain shadows on the x-ray film. Former patients with a litigious turn of mind seem to be getting more numerous. Hospitals and physicians should be advised that the most effective protection against court action, apart from prevention of injury to patients, is to have the true facts on which to base a defense. Opinion alone is not enough.

IDENTIFICATION

Another compelling reason for the preservation of x-ray films has been advanced recently by Singleton in the September 1951 issue of *Radiology*. This is the identification of bodies that are impossible to recognize by other standard means.

Death is an inevitable factor in everyone's life, but its impact on the lives of those who remain is considerable. Proof of death is required for many purposes, especially in matters of succession, inheritance, insurance, marital status, crime and civil litigation. Dr. Singleton's narrative emphasizes the importance of old x-ray films in the process of identification.

In September, 1949, fire broke out on the steamship Noronic while she was docked at Toronto. In a short time, 119 of her 527 passengers were burned beyond recognition. Because of the tremendous legal implications and the sentimental importance to the surviving relatives, the attorney general of the province of Ontario requested x-ray examination of the unknown victims. It was hoped that by this means a comparison could be made with x-ray films of the victims taken before death.

The Red Cross was charged with collecting x-rays of possible victims known to have been passengers on the ill-fated ship. As a preliminary survey, 78 bodies were x-rayed. Antero-posterior projections of the trunk and antero-posterior and lateral projections of the skull and any remaining extremities were made. Since the fire had occurred at night, such usual means of identification as clothing, jewelery and dentures had been removed by the victims. Moreover, the fire had destroyed fingerprint patterns so that this means of identification was not available. The job of recognition was extremely difficult.

As the Red Cross began to collect outside films, comparisons were made and where necessary, films of the unidentified bodies were made in projections comparable to the original films. The identification consisted mainly of accurate matching of normal bony structures, particularly at the margin of the joints. Congenital bone defects were of great value in this matching process.

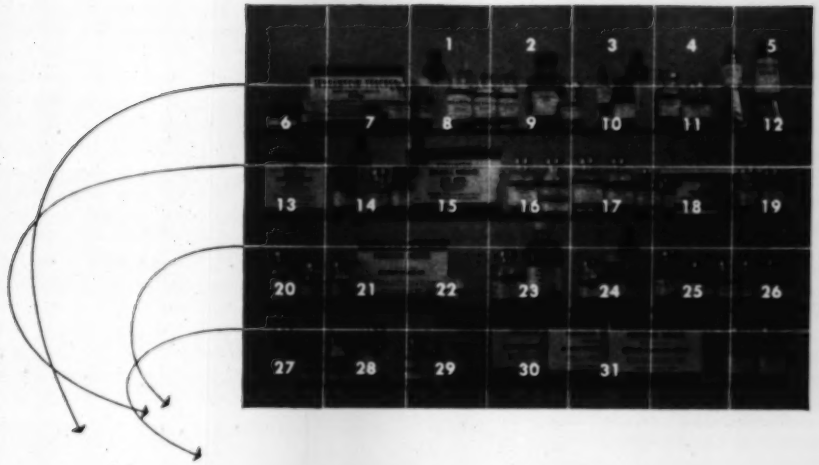
The portions of the body yielding positive identification were reported as follows: Skull, 4; cervical spine, 2; thoracic spine and chest, 13; lumbar spine and pelvis, 9; foot and ankle, 1.

Of the 35 persons whose films of previous x-rays were provided, 24 were positively identified. In five other instances, identity was suggestive. On the negative side, identity suggested by other means was excluded by incompatible x-ray comparison. In six cases, matching was impossible because of gross destruction of the parts or poor quality of the films made previously.

The identification of 35 bodies out of a possible 78 is not without significance. The lesson is plain. What would have happened if the x-rays of the identified victims had not been preserved and how many victims were not identified because their ante-mortem x-rays had been destroyed? In view of the preparations for civil defense that are now underway, an additional method of identifying victims of catastrophies, whether domestic or military, is a matter of some importance. The cost of storage space must be weighed against the hospital's duty to the community to assist any project that advances the public welfare.

Storage is a problem in almost every hospital. In many institutions, space allotted to storage has long ago been taken over by the staff as working space. The demand for space for new procedures, diagnostic, therapeutic, teaching or research is seemingly without end and some hospitals may feel that the space used to store x-ray films could be employed more productively.

Some institutions have solved the problem of storage of x-ray films by making photographic reductions of the originals. These are generally satisfactory for most fracture work, but have not been found entirely adequate for detailed chest studies. This is equally



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true of microfilms and the drawback will probably continue until more refined methods of photographic reproduction are evolved. The contracted copy of the original x-ray film is unquestionably of less medical and legal value than the original. Even so, it may represent a compromise between the need for medical and legal protection and the need of the hospital for the space that is occupied by the x-ray films.

Several methods of preserving reduced copies of x-ray films are in use in hospitals. One method is a simple contraction of the original film and filing in the x-ray department. Some hospitals prefer to extract films which have a particular medical, legal or research interest, retaining these originals indefinitely and reducing the remainder. In such cases, the radiologist, the attending physician or a committee composed of both, may review the films and indicate the originals that are to be retained indefinitely. This procedure appears to be the most successful yet devised to achieve the saving of space but is, at best, a compromise.

In another method, x-ray films are microfilmed in chronological order and stored in the x-ray department on a roll of film. The obvious drawback to this method is the necessity of revising much of the microfilm roll before the desired film is located. Review of a patient's x-ray films might involve the examination of several rolls so that the loss in man-hours might well exceed the gain from increased availability of storage space. Comparative film studies are difficult with this method.

A third method is to include the microfilmed original negatives with the microfilmed record of the patient's illnesses and to file these away as a complete record in the medical records department. This method makes it virtually impossible for the radiologist to examine several films simultaneously. Comparison is thus made difficult though not impossible.

Another suggested practice is to retain the microfilmed negative of the original film in the x-ray department and to attach a positive print of the microfilm to the patient's medical documents. This practice is useful only in the most obvious diagnoses. Physicians are accustomed to reading negative x-ray plates and the conversion from positive to negative may lead to occasional errors. It should be added, moreover, that the microfilming of the patient's records would present a difficulty if it were proposed to microfilm the reduced positive print. The x-ray picture would be almost unrecognizable.

As custodians of patients' records, hospitals are performing a public service to the community analogous to that of the custodians of public records. This duty has been assumed voluntarily and is, without doubt, a valuable service that is generally recognized by every community.

Hospitals have the legal right of custody of x-ray films and other patient records, but there may be some doubt that the right to retain includes the right to destroy when destruction of films may prejudice other interested parties. The suggestion has been made that hospitals who are embarrassed by the custody of x-ray films should offer them to the attending physician or to the patient before destroying them. It is not without merit.

The preservation or destruction of x-ray films seems to be a matter of choice for the hospital trustees. Each hospital must weigh the cost of storage against its duty to its patients, to its physicians, to the community that it serves and to itself. If x-ray films are to be destroyed, the medical staff should prepare instructions for the guidance of the radiologist and the total procedure for disposal should be reviewed by the hospital's legal counsel with approval by the governing board before being put into effect. In the last analysis, the hospital and the community that it serves will reap the fruits of its foresight or its lack of it.

Segregating the obstetrical patient

BECAUSE THE obstetrical patient is highly susceptible to infection, it is absolutely imperative that the obstetrical department or service in a general hospital be strictly segregated from other areas and types of patients. No patient who has an infection of any kind, such as a common cold, sore throat, discharging ear, open sore or abnormal discharge of any kind or condition where there is danger of transmitting infection should be admitted to or allowed on the obstetrical ward.

When an obstetrical patient who either has an infection or develops one later comes into the obstetrical ward, she should be transferred immediately. All well-regulated obstetrical departments or services usually provide an isolation unit entirely separate from the obstetrical ward for such patients. No degree of risk should be taken, for an infection may prove severe and fatal despite the use of sulfa drugs or other curative measures.

Not infrequently, patients with other kinds of conditions are admitted temporarily to the obstetrical department if there is an empty bed and there is a lack of accommodations available anywhere else in the hospital. This is a dangerous practice. One never knows what infection these patients are harboring or could transmit. Some hospitals allow clean medical cases to be accommodated in the obstetrical ward, but in this there is danger also for we do not know what infection these patients could be incubating.

Another practice that should be avoided is the interchange of personnel with other wards in the hospital. The nursing staff in the obstetrical department should restrict its duties to that area alone and

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nurses from other areas should not be given duty on the obstetrical ward.

Hospital visitors who have infected fingers, carbuncles, boils, sore throats or other local infections of a minor nature, also should not be allowed on the obstetrical ward. Too often they are conveyors of infection to mothers and babies. The gowning of these visitors might offer some protection in this instance.

One further precaution concerns the medical staff: No intern, resident, or regular member of the medical staff should attend obstetrical patients for at least 24 hours after handling a post-mortem case. If imperative, however, a change of clothes and the scrubbing of hands and arms (regular operating technique) should be accomplished.

The foregoing items may seem trivial, but after being the administrator of a maternity hospital, doing clinical obstetrics for a few years, and directing the hospital standardization activities of the American College of Surgeons for 28 years, I have seen many serious and widespread epidemics of infection in hospitals.

We must never discount the susceptibility to infection of the obstetrical patient during exposure of any kind, despite the discovery and use of the antibiotic agents. We should not lessen our precautions to prevent infection of the obstetrical patients.—MALCOLM T. MACEACHERN, M.D., C.M., *director of professional relations, American Hospital Association.*

Medical notes and comment

Ultra sonic energy

MANY exaggerated claims are being made concerning the value of ultra sonic energy (sound waves beyond the hearing range of human beings) in the treatment of a wide variety of diseases. This type of treatment originated in Europe and certain German physicians have claimed that it is of value in the treatment of malignancy, besides having mysterious effects other than those attributable to the heating of tissues.

The Council on Physical Medicine and Rehabilitation of the American Medical Association has made a critical evaluation of this form of treatment which is reported in the *Journal of the American Medical Association* (February 23, 1952, Vol. 148, No. 8, p. 646). The Council concedes that a proper dosage of ultra sonic therapy may produce valuable effects, and it has acknowledged that many hundreds of patients, particularly in Europe, have been so treated, apparently without harm. But the Council warns that ultra sonic energy also is a potent destructive agent and may be extremely dangerous if employed indiscriminately by unskilled persons. Physicians are urged therefore, to await the results of further cautious study of ultra sonic therapy before indiscriminately using the treatment in clinical practice.

Ultra sonic devices for use in medicine now are being imported from Europe, and some American manufacturers are starting to make them. Thus, hospital administrators and purchasing agents already may be aware of their existence through salesmen and supply houses. Also, because of the relatively large number of European-trained physicians now practicing in America, some hospital administrators may be faced with a demand by their staff physicians to acquire this equipment. In skillful hands the equipment could have beneficial effects on hospital patients. But administrators would be well advised to refer the question of the skill of the operator to the medical staff for evaluation before procuring such equipment.

Having explored rather fully the effects of maximal dosages of ultra sonic energy on living animals, the Council on Physical Medicine and Rehabilitation now proposes to investigate the effects of smaller dosages and to attempt to ascertain what the optimal dosages, if any, may be. It would therefore seem to be advisable at this time for hospitals not to install this equipment for any but experimental purposes, at least until the value and the method of its employment has been authoritatively established.

Teaching aid for venipuncture

In view of the potential need for people familiar with techniques of venipuncture and intravenous injection, the development of a lifelike model arm for teaching these techniques is a matter of more than passing interest. The model was developed by Commander J. V. Niiranen of the Naval Dental School.

One of the objections to giving nonprofessionals such training is that much of the practicing must be done on human beings by persons who lack adequate educational preparation. The first few tries of the novice may be a painful experience for the volunteer, so it is not surprising that there is some reluctance to undertake this training with live subjects. Moreover, training with live subjects is not entirely free from danger of infection and other complications. The new teaching model would eliminate much of this difficulty.

The model arm has a lifelike skin made of flesh-colored vinylite resin plastisols. Beneath the surface of the vinylite skin are rubber tubes simulating veins, filled with colored liquid. The liquid is held in syringe reservoirs connected to the tubes, which can simulate a realistic pulse beat with dextrous manipulation. The vinylite skin is said to be resistant to grease, oil, moisture and to most chemicals. It is also easy to wipe clean. The vein tubing rests on a half-inch felt padding that protects needle points from the plaster model underneath.

The model arm is portable and is now being used at the National Naval Medical Center in Bethesda, Md. Thickness of the vinylite skin can be varied so that trainees have to feel for the vein. The plastic can also be lubricated to make the veins slippery and hard to find like those often found in patients.

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IN PROVIDING an explosion safeguard system for hospital operating rooms, many elements are needed; but unless the hospital includes them all and develops a complete program, the system is worthless. In many cases, for example, explosion-proof electrical fittings and conductive operating room floors are installed in hospitals as standard equipment with no follow-through on the attendant equipment and administrative safeguards necessary for proper protection. Not only does such a program fail to contribute anything to safety, but in most cases it actually increases the hazard of explosion and electrical shock.

Among the major elements of any program to control hospital operating room explosions are (1) a system for grounding all personnel and equipment to a conductive floor and (2) an isolated, ungrounded wiring circuit serving the operating suite.

The recent report of the Bureau of Mines investigations into static electricity in hospital operating room suites certainly can be counted on to bring a great deal of attention to the need for complete compliance with the National Fire Protection Association recommendations for hospital operating rooms. (*See Recommended Safe Practice for Hospital Operating Rooms*, pamphlet 56 of the National Fire Protection Association).

Mr. Hudenburg is secretary of the Council on Hospital Planning and Plant Operation of the American Hospital Association and the Association's representative on the Committee on Hospital Inspections of the National Board of Fire Underwriters. He is also secretary of the National Fire Protection Association's Committee on Hospital Operating Rooms.

And inevitably, as the results of the Bureau of Mines findings are studied, it is to be expected that the grounding of surgeons and the nursing personnel with conductive shoes and the grounding of equipment with conductive casters will be given great impetus.

But as this increased compliance with standard recommendations develops, it is quite necessary that hospital authorities also study requirements for isolated, ungrounded circuits in hospital operating rooms. This is a feature of the requirements which, so far, has commanded little attention from anyone other than the electrical inspector and a few of the electrical engineers called on to make hospital layouts.

A conscientious effort is being made by flooring manufacturers to keep the resistance built into their floors in the general area of the lower limits, now prescribed as 25,000 ohms. These floors are intended to equalize electrical potentials, which requires the surgeon and the nurse to be electrically connected to that floor by means of conductive shoes.

Even though this system does not provide a substantial resistance to electricity between the individual coming in contact with a live wire and the ground, the protection against electrical shock is only relative. It is quite probable that the surgeon who touches a defective piece of electrical equipment will sustain a very definite sensation if his body is between the electrical circuit and the earth ground.

To protect operating room personnel against such unwelcome shock, pamphlet 56 of the National Fire Protection Association recommends the following very specific requirement:

"Section 5-5.

Arrangements of Circuits

(a) In anesthetizing locations an ungrounded electrical distribution system is required to reduce the hazards of electric shock and arcs in the event of insulation failure. Alternating current circuits shall be insulated from the conventionally grounded alternating current supply by means of one or more transformers which isolate the circuits electrically from the main feeder and from other circuits in the building . . . etc.

(b) Direct current circuits shall be insulated from their grounded feeders. This may be accomplished by means of a motor generator set or suitable battery system.

(NOTE: *Where the main electrical service is alternating current, and the emergency service is direct current, or vice versa, it is advisable to arrange the circuits so that no circuits except those for lighting or designated emergency outlets are connected to the emergency service.)*"

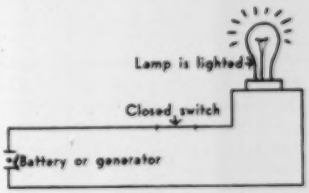


FIGURE A

Electrical current flows in a complete circle as in figure A. The flow of current is from the battery (or

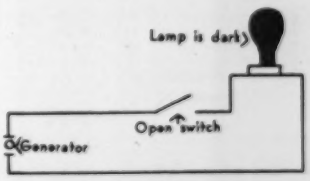


FIGURE B

generator) through wires to the electric lamp and then back to the battery. When, as in figure B, the circuit is interrupted by the opening of a switch, (1) there is no flow of current and (2) the lamp does not light.

Early in the history of electric power distribution, it was learned that the earth itself could be used as a return "wire" to complete the electrical circuit in the distribution of electricity. This means that if the power company runs one side of its generator circuit to the earth, it then can distribute current to consumers over a single wire, providing a ground wire to earth is connected to one side of the consumer's wiring system. (NOTE: Modern wiring utilizes a return wire to the utility sub-station as in figure B-1, but since that "grounded

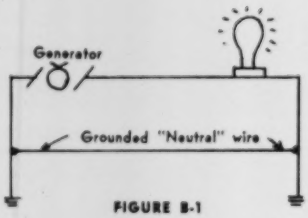


FIGURE B-1

neutral" wire is at the same electrical potential as the earth ground, it will be disregarded in this discussion since it does not materially change the grounding shock hazard.)

The current which enters a home consists of two wires. One, called the "hot" wire, is fed from a distant generator, and the other, called the "neutral" wire, is connected to the earth outside of the consumer's property. (See figure C.)

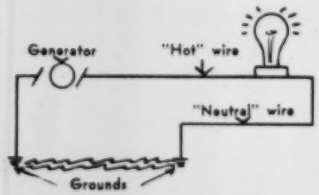


FIGURE C

The nature of this arrangement is such that a circuit can be completed anywhere along the hot wire, as in figure D, by carrying a drop through an appliance or light

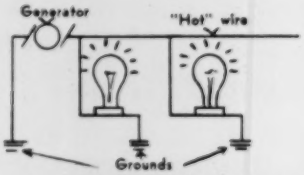
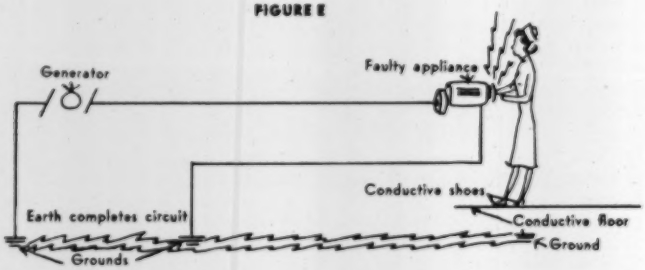


FIGURE D

directly to the neutral grounded conductor. It is this property that provides the shock hazard when conductive floors are introduced into the operating room as illustrated in figure E, which shows a

FIGURE E



defective electrical appliance, a conductive floor connected to the ground (which is at the same potential as the neutral conductor) and an individual wearing conductive shoes. In this figure the individual provides a path to earth ground for the electricity, although the amount of current passing is substantially limited by the resistance in the conductive flooring and the conductive shoes.

Figure F represents the use of what is known as an isolating one-to-one transformer. In figure F,

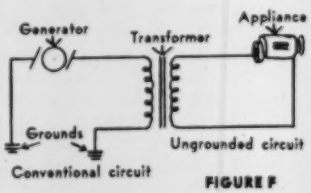


FIGURE F

the grounded circuit terminates at the transformer and the circuit feeding the operating room is a closed circuit which is not grounded. This is the ungrounded isolated circuit required for operating rooms under section 5-5 of pamphlet 56 as protection against shock hazard introduced by the installation of conductive floors and the wearing of conductive footwear.

It should be noted that these ungrounded electrical distribution systems are required for anesthetizing locations, but do not have to serve storage locations for combustible anesthetic agents, even though conductive floors are required for such storage areas.

This wiring system is effective as protection against shock, only as long as it remains ungrounded. There are many opportunities for it to become grounded through defective wiring. If, for instance, in the system of conduits and conduit fittings through which the wires pass, there is any contact between a wire bared of insulation and the conduit system, this would form an accidental ground.

A much greater chance of accidental grounding occurs when electrical appliances are connected into the operating room circuit. To comply with the standard, all portable equipment intended for use in the operating room must have its outer non-electrical metal parts connected to the building ground by means of a third wire in the connecting electrical cord. This connects the appliance to the explosion-proof fitting which is designed to accept a three-terminal plug, of which one terminal is intended to complete the grounding of the metallic shell of the appliance to the building ground.

Any failure of insulation or other defect which causes the electrical system within the appliance to ac-

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cidentally contact the grounded shell of the equipment, also would ground the entire electrical circuit. But unless it was readily apparent when the grounding did occur, this susceptibility to undetected grounding would nullify the effectiveness of the wiring system.

Pamphlet 56, therefore, requires a ground detection system for every operating room. This detection system is so contrived that whenever either of the conductors in the circuit is grounded (as might occur when a defective appliance is plugged into an outlet) a signal is immediately given. As long as the system is safe and isolated from ground, the signal indicator in the operating room will show a green light. But the moment a ground occurs, the green light goes off, a red light goes on, and a buzzer system begins to function.

In some hospitals this alarm also is connected to an alarm in the maintenance chief's headquarters so that he also will know if and when the system becomes grounded. It is most necessary, however, that the principal signal should show in the operating room, because it is the surgical personnel who must be protected against shock and who should know when they are in a position to receive such a shock from defective equipment.

There are various ways in which these warning systems work. The recommendations of the NFPA refer to a system operating by means of a relay, but a system which works by means of electronic tubes is equally acceptable.

The recommendations do specify, however, that there should be separate branch circuits feeding into each room used as an anesthetizing location. The reason for this is obvious, since the ground detector system should function only in the operating room in which a ground in the wiring system occurs.

In order to prevent inadvertent connection of ungrounded circuits to conventional circuits at some later date, the panel boxes feeding the ungrounded circuit should be physically separated from those feeding the conventional type of wiring. At the time of installation, the circuits should be specifically and clearly marked in the panel boxes as being ungrounded circuits, and a notice explaining the character of this electrical service should be posted by the hospital administration.

If the system is to be effective, its character, function and maintenance must be clearly explained to all personnel working in the operating rooms as well as to the maintenance staff. This is necessary if the safeguards are to receive proper respect and if the system is to be maintained so that it provides the required safety.

Compliance with these safeguards is not too difficult for most hospitals which are supplied alternating current by public utilities. Hospitals which have old direct-current generators that they themselves operate or which are in central areas of larger cities having direct current, however, probably will have quite a problem.

Electrical transformers are effective only for alternating current. The simple procedure of installing isolating transformers to solve the problem, therefore, offers no help if direct-current service is involved.

Probably the most sensible solution in these cases, would be to bring in from the public service company an alternating current line to serve the surgical area. Where this does not provide an acceptable solution, another alternative would be to add a motor generator set to the circuit so that the direct-current supply can be transformed to alternating current. A third method would be to install a suitable battery arrangement.

Provisions should be made to test the ground detector at least once a month to make sure it is functioning properly. The test, which should be made in each operating room, can be done very simply with the typical lamp device used by electrical maintenance men for testing circuits.

The test device usually consists of two metallic probes, with insulated handles, each of which is connected to one side of an electric lamp. When each of the probes is inserted into the proper part of a wall receptacle, the lamp should light but no signal should come from the ground detector. When one probe is inserted into the receptacle connected to the wiring system and the other probe is inserted in the contact connected to the grounding wire, however, the detector signal should indicate the ground by the red light and the buzzer. The ground detector also should change to red and the buzzer should sound if one of the probes is inserted into the portion of the receptacle connected to the wiring system and the other probe touches the receptacle face plate or any other metal part of the electrical system connected to the conduit system (which in the case of a nonmetallic face plate might be a screw which attaches the face plate to the junction box). Records of these tests should be kept, indicating who conducted them.

While it is not required that the conductive floor be connected to an earth ground, it is almost inconceivable that there would not be some connection to earth ground.

This discussion has dealt almost entirely with the isolated ungrounded wiring system because it appears to be one of the least understood aspects of the National Fire Protection Association recommendations. Another protection against shock is achieved, however, by connecting electrical apparatus introduced into the anesthetizing location to the wall receptacles by the three-wire cord.

This is important because when the grounding wire is properly attached, a defect within the appliance will immediately register on the ground detector. This not only protects personnel against shock, but it also indicates the possibility of a spark hazard which might be close enough to the zone containing a flammable anesthetic mixture to ignite that mixture.

For details about the flexible cord approved for anesthetizing locations, section 5-17 of the NFPA pamphlet 56 should be consulted. This section calls for a flexible cord which is continuous, does not have switches interposed between the appliance and the attachment plug, and is a type designated for extra hard usage in accordance with section 5021 of the National Electrical Code. The correct length of the cord is also quite important, and pamphlet 56 says "the flexible cord shall be of sufficient length to reach

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any position in which the portable device is to be used."

In order to prevent having a snake's nest of electrical cords on the operating room floor, it is recommended that all portable equipment be provided with some kind of electrical storage device on which the cord can be wound, in such a manner that it will not bend more sharply than a circle with a three inch radius.

To prevent undetected, accidental breakage within the flexible cord, the recommendations suggest using a cord which consists of two insulated conductors surrounded by, but insulated from, a braided wire. This surrounding braided wire should be connected to the ground terminal of the wall outlet and to the outside metallic shell of the electrical appliance.

Generally, the recommendations continue to require approved explosion-proof electrical receptacles and switches for installations below the five-foot level in the operating rooms of newly-constructed hospitals. For installation in existing buildings, they still suggest using replacement units which are in themselves explosion-proof and do not require alterations in the conduit system to comply with National Electrical Code requirements.

ENGINEERING and MAINTENANCE COMMENT

Institute change

HOSPITAL ENGINEERS and maintenance chiefs should note a change in dates for the Institute for Hospital Engineers.

The institute now has been scheduled for the week of June 2 to 6. It will be held in Chicago at the Knickerbocker Hotel, as previously planned. Announcements to member hospitals already are in the mails.

The advisory committee has planned the program with more time for discussion. There was a feeling that previously the men did not have as much time to talk over the subjects as they would have liked.

Ohio engineers organize

Ohio is the latest state to be added to the list of those that are assisting hospital engineers to organize and to promote educational activities in the maintenance field.

So far as we know, there has been no single state previously that has organized an institute on engineering and maintenance. This would then make the two-day institute held by the Ohio Hospital Association in Columbus on February 19-20 the first such venture.

Jay W. Collins, administrator of Glenville Hospital, Cleveland, was chairman of the Institute Committee. The balance of the committee was comprised of maintenance chiefs or chief engineers from Ohio hospitals, including Harold E. Elder, Miami Valley Hospital, Dayton; Charles A. White, Flower Hospital, Toledo; Earl L. Ross, Mount Carmel Hospital, Columbus, and Arthur Frampton, City Hospital of Akron. Harry C. Eader, executive secretary of the Ohio Hospital Association, acted as coordinator.

Numerically, the institute was successful in that it attracted 60 persons, representing 41 Ohio hospitals.

From a standpoint of quality the institute was equally successful, measured by both the formal presentations and the enthusiasm displayed by the student groups in discussion and in the concluding roundtable session.

The institute is one of a series of activities being developed for hospital engineers in the state. Semiformal organizations of the engineering and maintenance men in Ohio are being developed under the association's leadership, and the Cleveland area has already completed organization and instituted a series of educational sessions.

Ignition of nitrate film

The National Bureau of Standards has been able to demonstrate that cellulose nitrate motion picture films will decompose when stored at relatively high temperatures and eventually will spontaneously ignite.

Temperatures at which this was demonstrated were in the neighborhood of 150° F. maintained for approximately 17 days.

It is stated that these temperatures can be reached in storage vaults in abnormally hot summer weather. No mention is made of cellulose nitrate x-ray film, and of course it has not been in use for a number of years, but some of the older films may still be present in storage facilities.

Until further information is obtained and made available, it might be well for hospitals to insure that presence of steam pipes or other sources of heat will not cause film storage facilities to heat up beyond safe limits.

Hamfat and ingenuity

The ingenuity of the hospital engineer was demonstrated recently by an example reported by Richard Syoen, chief engineer at Ravenswood Hospital, Chicago.

He found it necessary to dismantle a high-pressure steam line that had been in service for 25 years and whose threaded joints were substantially frozen. Finding that ordinary penetrating oil evaporated under the heat of the steam line, he solved his problem with the aid of the hospital cook. Making a deal with the cook for a large piece of hamfat, he tied the ham above the recalcitrant joint, allowing the grease to slowly cook and run over the steam pipe fittings. He reports that, while the odor in the boiler room was particularly appetizing for several days, the treatment was extremely effective and the line was disassembled with ease. Mr. Syoen is secretary of the Tri-State Hospital Engineers' Association.

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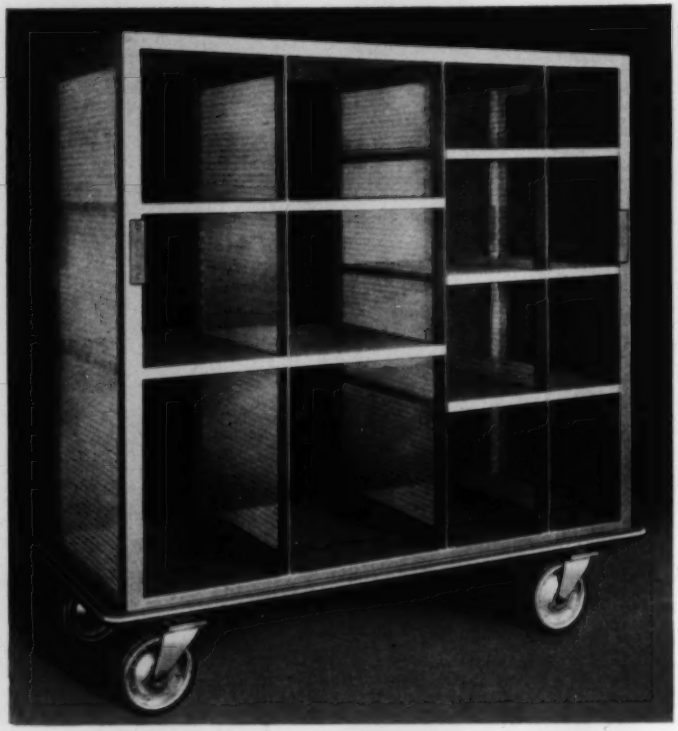

For the easy handling qualities so necessary to this large adjustable shelf servicer, we have provided it with 8" heavy duty double ball bearing swivel plate casters. The wheels are heavy duty cup and cone ball bearing steel disc type, with positive clincher grip tires of new live rubber. The tires are guaranteed not to creep or loosen in service, yet, when worn after years of service, can be easily replaced without the use of special tools. Both the caster swivel bearings and the wheel bearings are provided with fittings for pressure type lubrication.

The servicer illustrated was designed for transporting from the linen room to the patient floors all the linen and accessories necessary for servicing a minimum of twenty beds.

In the procedure set up at the University of Chicago Clinics, a pair of these trucks is assigned to each of fifteen linen stations. Each morning in the central linen room a truck for each station is loaded with the various items determined by the patient census on the floor or station concerned. The truck is then delivered to the station and placed in the linen room or closet, its companion truck from the previous day being then removed from the station and returned to the central linen room for next day's loading.

Since, to conserve necessary space, the linen closets are built of just sufficient size to accommodate one of these trucks pushed in sideways, four swivel casters are required. The Jarvis & Jarvis Magic-Swivelock device nevertheless permits these trucks to be delivered rapidly and easily down long corridors with the use of one attendant per truck.

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A personnel director's part in laundry management

ARTHUR F. HORNICKEL

ONE OF THE MOST complex problems faced by the institutional laundry manager is that of managing his personnel. In performing the job he must apply all the meanings of the word "manage": (1) to control and direct; to conduct; to guide; to train; to administer; (2) to render and keep submissive; to wield with address; (3) to treat with care; to husband; (4) to bring about by contriving, and (5) to direct affairs; to carry on business.

He not only must bear the responsibility of supervising the proper processing and distribution of linens, therefore, but he also must be a leader, a guide, a teacher, a disciplinarian, a shepherd, a contriver, and even a chaplain.

SOURCE OF AID

These are the laundry manager's problems. What are the solutions? Where in the hospital can he find the necessary information and assistance to ease his burden? The answer is simple—either from his personnel manager or, if there is no such position in his hospital, from the administrative personnel responsible for formulating the policies of a personnel department.

If the laundry manager likes people and enjoys working with them, he has overcome a large part of his problem. If he does not enjoy working with people, his struggle certainly is going to be uphill, and he simply must sit down and take stock of himself—his ideas, methods and philosophies. An honest analysis of himself and the subsequent realization of his own shortcomings should make his problem easier.

The greatest aid, however, should come from the personnel department or from the administration.

There are several ways in which the personnel department can be of help to the laundry manager.

PERSONNEL PROGRAM

1. There should be an established personnel program that has been set up by management to help achieve the objectives of the institution. With such a program, management takes care of the personnel aspects of the hospital's departments in the same planned manner that is used in dealing with other major aspects of running the hospital.

2. The personnel manager must be a man who can handle many tasks in the hospital. It is reasonable to assume, however, that the laundry manager may expect the following from the personnel manager or from his department:

▸ The personnel manager should know the complete function and problems of the laundry department and its relation to the other departments of the hospital. His job requires that he keep studying the conditions throughout the laundry.

▸ The personnel manager should have a detailed description for each position in the laundry. The personnel and laundry managers also should set up some plan for evaluating the various jobs in the laundry according to relative importance, difficulty and skills required. Job analysis involves the evaluation of the job descriptions which should be based on the duties, operations and relationships of the various jobs.

WORKING CONDITIONS

▸ The personnel manager should be familiar with the working conditions of the laundry. An unsatisfactory physical environment—poorly ventilated, poorly lighted, damp and noisy plants—may cause unrest among the laundry employees. These factors have a bearing on the worker's happiness in his job and also affect his ability to produce.

▸ The personnel manager should try to impress upon the administrator the importance of all the functions and responsibilities of his own department. "Personnel management is neither originated nor is it solely carried out by the personnel department but is a major responsibility of management. This department gives specialized services to the operating departments to make their work more effective. Therefore, it should probe into every phase of personnel relations to discover points or irritations needing remedial action, evaluate the effectiveness of current practices, and suggest programs based on these findings."* These studies may reveal employee dissatisfaction due to poor supervision, poor working conditions, inadequate training programs, lack of merit promotions, or other aspects of personnel management vital to effective operation.

WAGE SCALES

▸ By the same token, it should also be the responsibility of the personnel manager to keep the administrator and his department informed on current wage scales in comparable hospitals and, if possible, to keep the wages of his institution in line. Some organizations conduct community surveys regularly to discover their standing and to learn whether or not the institutional wages and working conditions in the community are generally accepted.

▸ The personnel department should

Mr. Hornickel is administrative assistant of the Long Island College Hospital, Brooklyn, N. Y.

* *Personnel Management* by Scott, Clothier, Mathewson and Spriegel. Third edition. McGraw-Hill Book Company.

provide the laundry manager with statistics that may be used to advantage by him. A report on the laundry turnover rate gives the laundry manager an incentive to study the problem, particularly if the rate is high. His own supervision may be faulty; adverse working conditions may be a factor, or low wage scales and an unstable labor market may be the cause of high turnover.

▸ The personnel manager should be sufficiently acquainted with the number and types of laundry employees necessary to properly staff the department so that he may sit in as a third party with the administrator and the laundry manager when they discuss the laundry personnel budget.

PROGRAM OUTLINE

▸ The personnel manager, together with the laundry manager, should arrange the programs necessary to provide the laundry manager with competent and satisfied employees. The groundwork might be started through:

1. Screening and orientation of new applicants.
2. An employee handbook or personnel manual.
3. Proper job training.
4. Employee's health service.
5. Promotional incentives.
6. Flexible policies and benefits to increase long service.
7. Promoting employee job satisfaction.
8. Exit interviews.

▸ A chart outlining the laundry accident rate is helpful. Remedies may be proposed to prevent: (1) The overworking of employees; (2) accidents due to lack of proper safety devices, and (3) the keeping of accident-prone personnel in positions where accidents are most likely to happen.

▸ The personnel manager should set up a grievance procedure that can be used by any employee who has a gripe. If the complaint is reasonable, the situation should be corrected. If the complaint has no basis, the manager should explain to the employee why corrective measures are not necessary. While the employee is new, the personnel manager should keep in close contact with him by means of follow-up interviews.

These eight points form the outline of a program and policy necessary to cope with personnel problems met in managing an institutional laundry. The details, however, must be worked out by the administrator, the personnel director and the laundry manager. The final program definitely should aid the laundry manager in his attempt to manage his personnel successfully and competently.

LAUNDRY MANAGEMENT COMMENT

Commercial laundries

THE ADMINISTRATOR of a 100-bed hospital has inquired about the possibility of reducing costs by using a commercial laundry in preference to the hospital laundry inasmuch as the commercial operator states he can save the hospital from $10,000 to $20,000 a year if the work were done on the outside.

The fact that two-thirds of hospitals from 50 to 99 beds operate their own laundries and that 80 per cent of hospitals from 100 to 249 beds operate their own laundries, would seem to indicate that experience dictates this method.

While there are a number of hospitals having their laundry done by commercial plants, several have reported that they were dissatisfied with this method and were intending to construct their own plants. The reasons for doing so were:

1. Flexibility. The ability to service any particular department or area of the hospital when shortage of supply makes it advisable.

2. Control of formulas used. Proper sorting of linen according to degree of soil makes it possible to vary the procedure and thus control loss of tensile strength when soil is light.

3. Control of laundry operation. Demand for linen may vary and it is much easier to meet such needs when control of the laundry operation is retained by the hospital.

4. Control of contaminated linen. This is, of course, possible when linen is being sent to a commercial laundry but it is much more satisfactory to conduct sterility tests and tests on the wash water for residual contamination.

Information available on laundry costs is not altogether satisfactory, but appears to indicate that a 100-bed hospital should launder in the neighborhood of 8,400 pounds per week and do so at a cost of approximately four cents per pound.

Linen marking

The process of marking hospital linens has been a subject long disputed. John Kenney of The New York Hospital, New York City, has used a marking system for a number of years and is well satisfied with the results.

The marking machine used at The New York Hospital is operated by foot and permits the operator to use both hands in handling the material to be marked. The name die is slotted so that interchangeable type may be used to designate the different departments and date the time the linens are placed into service. Name dies are deeply engraved and use a simple type face from one-eighth inch high to as large as 2½ inches in size, making the marking easy to read.

In the matter of no-heat indelible inks and silver inks, Mr. Kenney prefers the silver base type. The linen at the hospital is marked and heat is applied to the mark by the process of simply passing a hot iron over it. The indelible ink undergoes a chemical reaction and is permanently imprinted into the material.

Readers of this department are invited to send in questions, problems, and solutions to problems involved in effective operation of the hospital laundry. Queries will be channeled to appropriate authorities for answers. Where the material is of general interest, portions of it may be published. Address all correspondence to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10.

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Standardization and reduction of the modified hospital diet

SISTER MARGARET GERTRUDE, S.C.L.

CURRENT DIETARY management looks toward simplifying and reducing the special, or modified, diet to bring about greater uniformity and standardization. Ordinarily, these modifications of the normal diet are classified as those which have undergone changes in consistency, as a semi-solid or full liquid diet; in energy value, as the high or low calorie diet; or in the amounts of food nutrients, as the high carbohydrate or high vitamin diet.

Treatment by diet should be followed through the use of either qualitative diets which prescribe the omission of certain articles of food (if weight reduction is desired), or quantitative diets which consider the values of foods in terms of specific nutrients as fats, carbohydrates and proteins. These diets may be measured with a teaspoon and measuring cup, or, if these are inadequate, through accurate weighing with a food scale. Whatever the modification, the essentials of the adequate diet must be included in the daily planning.

REVISION NEEDED

The need for revising former practices of diet therapy is becoming more important. The present state of knowledge of nutrition is incomplete and as research establishes new facts, dietetic treatment will have to be modified accordingly.

Modified diets frequently are planned without concern for the long time interests of the patient. Some diets prescribed for the control of allergies have actually produced deficiency diseases. Many diabetic diets are inadequate not only in calories but in protein, salts and vitamins as well. Therapeutic diets prescribed for treating arthritis have not been found efficacious as there is no evidence for the need of a diet differing from the optimum or ideal diet. There is an increased acceptance among physicians of certain basic principles of diet therapy in those diseases in which diet is of extreme importance. There is still wide difference of opinion, however, in certain other conditions in which diet is prescribed.

Modified diets usually make up a total of 11 per cent to 16 per cent of all diets in the general hospital and in the case of the private or specialized hospital, the number may run as high 28 per cent or more. The maternity hospital no doubt will show a much lower total than one catering to general practice.

SPECIAL DIET COSTS

Often problems in food service administration are reflected in the preparation of these special diets. Labor costs are higher for this type of service because of the increased number of personnel necessary for the preparation of items. Skilled and unskilled workers must staff the centers where the special foods are prepared. If the patient is to receive a carefully checked tray, close supervision must be maintained.

Food costs may be higher for the therapeutic diets because of the waste in food preparation (e.g., cutting off the fat of meat) or through the purchase of special foods. Increased costs are represented in the special equipment needed for service, as for example, airline service, which insures carefully controlled temperatures of foods.

Investments in large and small equipment, both standard and specialized, which are necessary for the preparation of special items, result in higher costs for maintenance and repair. More surface area allotted to the unit means more walls, corners, counters and sinks to be cleaned. Replacement of parts will have to be made, the more so if the selection of equipment has not been carefully thought out. Certainly, stainless steel or aluminum equipment will withstand greater wear and tear than that made of other metals.

STANDARDIZATION STEPS

Recognizing that the need for regulation does exist, various attempts toward standardization can be made. One of these may be the setting up of a dietetic terminology. The difficulty now is that several factors influence the naming of the diets. The disease condition itself may determine the nomenclature, as in the case of the ulcer or the cardiac diet, but it is undesirable psychologically if the patient is reminded of his disease every time his tray is delivered with the tray card listing the reason for his special diet. The diet may be just as suitable for other conditions but it is not prescribed because of the lack of knowledge of the underlying principle of modification.

In some hospitals, the diet carries the name of the doctor who was the originator, but this tells nothing about the true nature of the diet. Such a practice should be discouraged as much as possible. Often a standard hospital diet carries the same prescription and much time can be saved and much

Sister Margaret Gertrude is instructor in nutrition and dietetics, Saint Mary College, Xavier, Kan. This article is adapted from a paper presented at a meeting of the Colorado Hospital Association in Denver, November 1951.

The Dietetics Administration department is edited by Margaret Gillam, dietetics specialist.

labor eliminated by standardizing this particular special diet.

Many hospitals find the ideal in eliminating the name of the disease and using a name which describes the diet in terms of the modification that has been made, as for example, in nutrients or consistency. Such terms as the "high protein" or the "low sodium" might appear on the diet lists in such institutions.

TERMINOLOGY DIFFERENCES

Variation in terminology is noted in the present conceptions of the salt and sodium contents of diets and the confusion and misinterpretations arising from the use of the terms "low," "restricted," and "salt free." The results of questionnaires sent to 24 hospitals showed that 20 different terms were used to describe the sodium content of diets prescribed for patients with cardiac disease. The most frequent terms reported were: "Low-sodium diet" and the "low-salt diet." On the low-sodium diet in eight hospitals, 200 mg. of sodium were allowed whereas in others, the allowance varied from 125 to 800 mg. The range for the low-salt diet was from 0.8 to 8 gm. of salt. Usually a committee of dietitians and doctors or dietitians alone had established the terminology for the diets.

The American Dietetic Association has attempted to clarify the terminology of therapeutic diets through its "Glossary of Dietetic Terms," which was prepared by a committee of the Diet Therapy Section published in 1946 as an appendix to the *Handbook of Diet Therapy*. The revised glossary was completed in 1951 and will be helpful in bringing definitions up to date. It "provides a system of nomenclature which is descriptive of diets, is designed to encourage uniform therapeutic practices, and avoids undesirable connotations. The use of this glossary will aid in simplifying and reducing the number of diets through the use of dietetic terminology and principles."

The basis of a sound plan for the regulation of some special diets is the well planned general diet which insures adequate nutrients and satisfies the patient's needs in regard to such problems as his race or religion. Careful planning results in many of the food items being used on other special diets without special preparation. The American Hospital Association provides such a service in HOSPITALS which publishes a Master Menu that can be adjusted to meet the principles of commonly used therapeutic diets. Such a plan, however, may be altered by the availability of local food supply or the dietary patterns of the race of the locality.

Some hospitals with a full dietetic staff or with a program for dietetic interns find a menu conference valuable in eliminating or reducing the profusion of special diets. The general diet for the following week is studied and menus for the most common modified diets are planned on that basis. Food requisitions are then drawn up for as many items as can be prepared in the main kitchen units, reserving only a minimum for preparation in the special diet kitchen.

NEW MANUALS

The adoption of a diet manual or the revision of a present outdated one is another suggested means of eliminating or reducing special diets. The project should be undertaken with or approved by the medical staff or their appointed committee. A simplified manual should be adopted, bearing in mind that copies of the manual will be used in the serving kitchens, nurses' stations, and other hospital units. If the diets have nutritional deficiencies, a note to that effect should be made. An up-to-date bibliography of reference and an index should be included and a guide to physicians inserted as an appendix or supplement. If the hospital uses the description of the modification for the nomenclature of special diets, the appendix may make recommendations for the use of the diet under the headings of particular diseases. The appendix section should be designed to facilitate removal if later nutritional research necessitates changes in the prescription.

Some local groups are formulating city-wide diet manuals as a basis for standardization of dietary modifications. The regulation of the most commonly used diets, as the diabetic or the low sodium, serves as the foundation on which the work is built. Such a step requires the cooperation of the local medical societies but this is usually forthcoming if the evidence for the need is presented.

THE DIABETIC DIET

Standardization of the diabetic diet is now being brought about through the use of food exchanges upon which the principle of the calculation of the diabetic diet is based. Previous methods used in estimating the composition of foods in the calculation of the diabetic diet have been widely varied and needlessly prolonged, proving that standardization is necessary. Six years ago the former secretary of the American Diabetes Association appealed for greater standardization of values on food composition in the dietary management of diabetes. He believed that if consistent terminology were used in dealing with food problems of diabetic patients, great benefits could be gained. An attempt had been made earlier to meet this need for standardization in the Cincinnati hospitals through the publication of a pamphlet, *Food Values in Terms of Household Measures*, which had been prepared by the Diet Therapy Section of the Cincinnati Dietetic Association in conjunction with the Council on Diabetes of the Public Health Federation.

Often in private practice there is a lack of time for detailed dietary planning and patient instruction. For this reason, it has been emphasized that if a program of education in diabetes is to be effective, uniformity and simplicity in dietary instruction must be followed.

In 1947, at the invitation of the American Diabetes Association, a committee was set up for the purpose of working towards a solution of these problems, the cooperating organizations being the Committee on Education of the American Diabetes Association, the American Dietetic Association, and the Diabetes Branch of the U. S. Public Health Service. The objectives of this joint committee were (1) to prepare food values suitable for use in dietary calculation and (2) to devise a simplified method for planning the diet by including

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"exchange lists" of those foods of similar food value.

Faced with the lack of uniformity in the composition of foods because of the many differences in variety, in the degree of maturity, in conditions of growth and even in the method of harvesting, storage and preparation, the committee weighed and considered these factors in setting up a very abbreviated table of food values to be used in calculating the diabetic diet.

FOOD EXCHANGES

The common foods that are allowed are divided into six groups as exchanges of milk, vegetables, fruits, bread, meat and fat, these divisions according to composition. Each food exchange includes the kinds and amounts of food that have about the same nutritional value in carbohydrate, fat and protein. When one exchange in a group is allowed, the patient may have one slice of bread or one-half cup of fresh lima beans, one-half cup of white mashed potatoes or any of the other substitutions that are suggested.

The simplified classification of the vegetable exchanges includes those vegetables of negligible carbohydrate, protein, and fat content which need not be figured in the diet unless more than 200 grams are used at one meal. The vegetables which contain greater amounts of carbohydrate, and which formerly fell into the 6 per cent, 9 per cent or 10 per cent classifications, comprise the second type and are figured in the diet on a basis of 7 grams of carbohydrate per 100 grams of serving. This is a weighted average figure. Vegetables of a higher carbohydrate content are carried in the bread exchange list.

The calculation of the diabetic diet is simplified through the use of the short list of food values that are given. First, basic protective foods that are recommended for the normal individual such as milk, meat, whole grain cereal or bread, fruit, vegetables or butter are figured in the diet and finally the remaining nutrients, fats, carbohydrates, and proteins required to complete the diet prescription are figured.

Reports from the American Diabetes Association show that the new plan is receiving widespread acceptance. Through the use of the simplified method, they find that it is now possible to calculate diabetic diets with considerable ease, resulting in a saving of time for both the dietitians and the physician. Variety is assured through the food exchange lists and the patient benefits by a diet that will help him make substitutions to suit his food habits.

The figures for the calculation of the diet along with the food exchange lists are published under the auspices of the Diabetes Branch of the U. S. Public Health Service. Copies may be purchased from the Health Publications Institute, Inc., Raleigh, N. C., for a nominal sum. Also included are six sample meal plans which were planned to meet different caloric levels with different amounts of carbohydrate, fat, and protein.

SUMMARY

The reduction of diets by standardization is necessarily a good objective in revising former practices of diet therapy, a step necessitated by increased prescriptions for special diets with mounting costs in labor, food, maintenance and repair. Simplifying dietetic terminology and the nomenclature of the diet itself, emphasizing the need for sound menu planning, vitalizing the menu conference, and adopting a hospital or city-wide diet manual are factors which can influence the standardizing process.

Greater patient satisfaction and a saving in time for physician and dietitian that can be used profitably to contribute to greater efficiency of patient services result from the use of the "food exchange system" upon which the calculation of the newly developed standard diabetic diet is based.

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DIETETICS ADMINISTRATION COMMENT

Commodity highlights

A PUBLICATION of the Bureau of Agricultural Economics, U. S. Department of Agriculture, predicts what can be expected in the commodity markets this year.

Moderately larger meat production is expected this year; during most of 1951, supplies were consistently below the year before. With stronger consumer demand in prospect, it is probable that dairy prices this year will continue higher than a year earlier. Per capita supplies of eggs this spring are likely to be larger than a year earlier and prices may stabilize somewhat below those of the same months of 1951. Fats and oils prices continue to fall, and are now sharply lower than a year ago; larger supplies are the reason.

Small cold-storage stocks indicate somewhat higher prices this winter and early spring for apples and pears. Oranges may rise slightly, but grapefruit prices will probably not change much. Supplies of such vegetables as dry onions, cabbage and carrots are smaller than last year.

Dietary services

Dietitians interested in obtaining more complete information con-

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February 26, 1952

Mr. H. W. Clarke, Jr.
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Dear Mr. Clarke:

Our new 50-bed hospital having been in operation nearly one and one-half years, I feel well qualified and happy to express our complete satisfaction with the Mealpack System as installed here.

You will recall that in our early discussions during the planning of Tipton Memorial, we stressed the importance of superior dietary service toward popular acceptance of our Hospital in this community. I can say without reservation that we have received nothing but compliments on our food service.

We attribute this "fulfillment" of the Administrator's "dreams" largely to the fact that our well prepared foods are served in perfect condition with the Mealpack equipment and procedures you have established for us.

Although Mealpack appeared more expensive than our alternate plans at the outset, we have found in the long run that both overall equipment and operating costs have proven to be materially less. We have virtually no food waste because preparation and portioning are controlled at the same kitchen; our personnel requirements are the same (if not less) than at other hospitals of comparable size.

Further, we have found both maintenance and replacement costs to be very moderate - particularly in view of the excellent service that Mealpack makes possible.

We heartily commend the Mealpack System in all respects, and would advise any hospital to give it fullest consideration for all dietary improvement programs or new construction.

Very truly yours,

TIPTON COUNTY MEMORIAL HOSPITAL

Harry L. Gable,
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cerning the elements for hospital planning appearing in this issue are referred to the November 1951 issue of HOSPITALS, pages 85-93. A full discussion of dietary services for 50 to 200-bed hospitals appears on these pages.

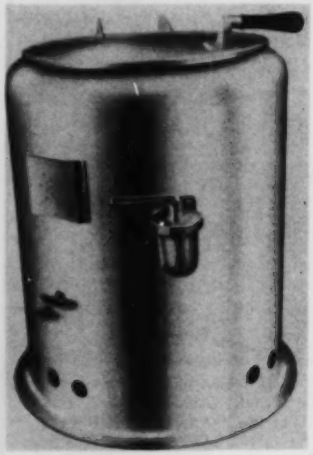
The article discusses in detail topics such as patient service, storage facilities, pre-preparation and preparation units, and cafeteria and dining room facilities.

Self-contained kettle

A new aluminum gas-fired kettle can be used where quantities of food have to be prepared and steam is now available (4D-1)*.

The sanitary self-contained kettle can be used for preparing meats, fresh fruits and vegetables, frozen foods, sauces, soups, stews, and other dishes. It is said to save up to 50 per cent cooking time on meats with shrinkage held to a minimum.

Cooking is done by means of gas heat, applied directly to a heavy gauge seamless aluminum shell, from specially designed burners. The rapidity with which aluminum spreads heat enables the entire container to do the cooking.

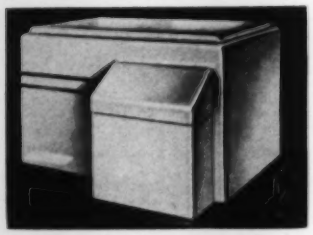


The kettle is available with two types of removable inside containers—one has a smooth, rounded bottom for easier stirring with convenient lift out handles; the other is equipped with a tangent draw-off and easy to clean valve which provides sanitary protection and which makes emptying easy.

Ice machine

A new counter model ice tip machine, 20 x 32 x 20 inches, is now on the market (4D-2)*. The compact unit produces ice tips of any desired size and is capable of making over 100 pounds of ice a day. The machine is completely automatic and stops operation when storage of ice is at capacity (1.5 bushels), and starts again when the supply of ice is partially expended.

The ice forms on freezer tips located in the bottom of the freezer tank—is released from the freezer tips during the defrost cycle, and rises to the surface of the water where it is removed to the storage bin by a revolving paddle. The



continuous motion of the paddle circulates the water and insures the clear freezing of the ice tips.

The ice tips have no flat surfaces and will not stick together in storage. They are cylinder-shaped and round on both ends.

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

Master Menus for May

THE MAY SERIES of the American Hospital Association's Master Menu is printed on this and the following pages. A general and seven modified diets are provided in the menu plan.

These menus reduce to a minimum the number of diets, simplify planning, decrease costs and conserve food preparation time. The general diet forms the basis of the seven most commonly used modified hospital diets. Selections to be served on the general diet are set in boldface type in the Master Menus.

Modified diets in the menu plan are the soft, full liquid, high protein, high calorie, low calorie, low fat and measured or weighed. All except the full liquid diet have been planned to include the nine food essentials and servings required for nutritional adequacy. The menus are adaptable for selective service.

Consideration is given in planning to flavor, variety, attractiveness and general acceptance by patients. Color is a factor, and color combinations must harmonize. Foods in each meal are planned in a variety of forms, not all flat, high, or round but a pleasing combination of shapes.

Master Menu kits containing the revised wall cards, sample transfer slips and the "Master Menu Diet Manual" are available to users of the menus. The kits are priced at $2 and may be secured by writing the Editorial Department of HOSPITALS. Single copies of the manual may be purchased for $1.50.

Full directions for using the Master Menu are in the manual.

May 1

1. **Orange slices in juice**
2. Orange juice
3. **Shredded wheat or farina**
4. **Scrambled egg**
5. Grilled Canadian bacon
6. **Hot biscuits—honey**
7. **Barley broth**
8. **Saltines**
9. **Roast shoulder of spring lamb or veal**
10. Roast lamb
11. **Scalloped potatoes**
12. Potato balls
13. **Diced straightneck squash**
14. Diced straightneck squash
15. **Tossed leaf lettuce salad**
16. **Poppy-seed sweet dressing**
17. **Strawberry ice cream**
18. Cranberry ice
19. Cranberry ice (no cream)
20. Unsweetened canned boysenberries
21. Lemonade
22. **Puree of split pea soup**
23. **Toast sticks**
24. **Cold cuts—potato salad**
25. Cold sliced chicken
26. Cold sliced chicken—cabbage and carrot salad
27. Baked noodles
28. **New beets and greens**
29. ———
30. ———
31. **Fruit cup—May Day cup cakes**
32. Canned peeled apricots
33. Cherry gelatin with custard sauce
34. Grapefruit baskets
35. Apple juice
36. **Bread**

May 2

1. **Grapefruit**
2. Grapefruit juice
3. **Brown granular wheat cereal or corn flakes**
4. Poached egg (omit on Normal Diet)
5. Crisp bacon
6. **French toast—syrup**
7. **Essence of vegetable soup**
8. **Whole wheat wafers**
9. **Baked breaded flounder fillets**
10. Broiled flounder fillets

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Floor Nurse

"How can I save time in the morning?"

Cutting corners wherever you can. Serve Kellogg's Individuals every morning and you'll get through your breakfast rounds faster. No time-consuming measuring and dishing out... Kellogg's cereals taste so good that you'll never have to coax your patients to eat up!

Dietitian

"How do I get patients to enjoy breakfast?"

By serving the cereals they prefer at home—Kellogg's cereals. Kellogg's Individual Packages insure each patient his favorite cereal. All Kellogg's cereals either are made from the whole grain or are restored to whole-grain levels of thiamine, niacin and iron.

Kellogg's

OF BATTLE CREEK
MICHIGAN

11. **Duchess potatoes**
12. Riced potatoes
13. **Pimiento wax beans**
14. Wax beans
15. **Celery and rose radishes**
16. ———
17. **Lattice-top rhubarb pie**
18. Molded chocolate pudding
19. Grape sponge
20. Unsweetened canned peaches
21. Blended citrus juice
22. **Pineapple juice with orange sherbet**
23. ———
24. **Egg cutlet with parsley sauce**
25. Creamed eggs
26. Low fat tuna with lemon
27. Stuffed baked potato
28. **Spinach with lemon**
29. **Tomato salad**
30. **Herb French dressing**
31. **Chocolate brownie**
32. Canned bing cherries
33. Molded chocolate pudding
34. Unsweetened canned bing cherries
35. Consomme or juice
36. **Bread**

May 3

1. **Orange juice**
2. Orange juice
3. **Wheat flakes or oatmeal**
4. **Soft cooked egg**
5. Grilled link sausages
6. **Toast**
7. **Noodle soup**
8. **Saltines**
9. **Roast fresh ham—cinnamon applesauce**
10. Braised beef
11. **Brown paprika potatoes**
12. New potatoes
13. **Seven-minute cabbage**
14. Sliced carrots
15. **Endive and julienne beet salad**
16. **Fresh horse-radish dressing**
17. **Date tapioca, whipped cream and chopped walnuts**
18. Apple tapioca
19. Raspberry gelatin
20. Unsweetened canned fruit cocktail
21. Grapefruit juice
22. **Tomato and rice soup**
23. **Crisp crackers**
24. **Creamed dried beef on Chinese noodles**
25. Macaroni and cheese
26. Baked veal chop
27. Whipped potatoes (omit on Soft Diet)
28. **Asparagus tips**
29. **Tossed salad**
30. **Celery-seed dressing**
31. **Pear and plum compote**
32. Canned pears
33. Vanilla rennet-custard
34. Unsweetened canned pear and plum compote
35. Mixed fruit juice
36. **French bread**

May 4

1. **Grapefruit**
2. Prune juice with lemon
3. **Rolled wheat or crisp rice cereal**
4. **Scrambled egg**
5. Crisp bacon
6. **Cinnamon toast**
7. **Beef bouillon**
8. **Crisp crackers**
9. **Baked stuffed half broiler**
10. Roast chicken
11. **Whipped potatoes**
12. Whipped potatoes
13. **Green Lima beans**
14. Patty pan squash
15. **Mixed fruit salad with pecans**
16. **Fruit salad dressing**
17. **Lemon custard ice cream**
18. Lemon custard ice cream
19. Lemon ice
20. Sliced orange
21. Tomato juice
22. **Cream of mushroom soup**
23. **Saltines**
24. **Molded lime cottage cheese salad—beef relish sandwiches**
25. Minced beef sandwich—peas
26. Cold roast beef—peas
27. Baked yams (omit on Soft Diet)
28. ———
29. **Carrot sticks**
30. ———
31. **Fresh or frozen strawberries**
32. Jellied canned fruit
33. Baked custard
34. Fresh strawberries
35. Orange juice
36. ———

May 5

1. **Tomato juice**
2. Tomato juice
3. **Puffed wheat or oatmeal**
4. **Poached egg**
5. Crisp bacon
6. **Corn muffins**
7. **Chicken rice soup**
8. **Melba toast**
9. **Braised liver**
10. Pan-broiled liver
11. **New potatoes in cream sauce**
12. New potatoes
13. **Sliced new beets**
14. Sliced new beets
15. **Shredded cabbage and raisin salad**
16. **Sour cream dressing**
17. **Chilled pear with custard sauce**
18. Chilled pear with custard sauce
19. Mocha sponge
20. Fresh apple
21. Grapefruit juice
22. **Cream of corn soup**
23. **Crisp crackers**
24. **Glazed Canadian bacon—parsley rice**
25. Crisp bacon
26. Broiled lamb chop
27. Parsley rice
28. **Green beans**
29. **Fresh pineapple fan and cherry salad**
30. **Clear French dressing**
31. **Orange chiffon cake with orange frosting**
32. Prune whip
33. Strawberry gelatin
34. Unsweetened canned peaches
35. Pineapple juice
36. **Bread**

May 6

1. **Blended citrus juice**
2. Blended citrus juice
3. **Hominy or wheat and barley kernels**
4. **Soft cooked egg**
5. Crisp bacon
6. **Toast**
7. **French onion soup**
8. **Crisp crackers**
9. **Sirloin broil, cut slantwise**
10. London broil
11. **Baked potato**
12. Baked potato
13. **Fried eggplant or spinach**
14. Chopped spinach
15. **Tossed lettuce and tomato salad**
16. **Vinegar-oil dressing**
17. **Chocolate fudge pudding**
18. Lime ice
19. Lime ice
20. Orange and strawberry cup
21. Grape juice
22. **Vegetable soup**
23. **Saltines**
24. **Salmon salad—potato chips**
25. Creamed chicken—carrots
26. Hot sliced chicken—broccoli
27. New potatoes
28. ———
29. **Radishes and raw carrot sticks**
30. ———
31. **Half grapefruit with strawberry garnish**
32. Grapefruit sections
33. Vanilla blanc mange
34. Unsweetened canned boysenberries
35. Cherry juice
36. **Cloverleaf rolls**

May 7

1. **Orange juice**
2. Orange juice
3. **Bran flakes or farina**
4. **Scrambled egg**
5. Grilled link sausages
6. **Toast**
7. **Consomme**
8. **Saltines**
9. **Baked ham slice**
10. Broiled whitefish
11. **Mashed potatoes**
12. Riced potatoes
13. **Asparagus tips**
14. Asparagus tips
15. **Peach, banana and cherry salad**
16. **Chantilly dressing**
17. **Lemon meringue pie**
18. Lemon meringue pudding
19. Whipped cherry gelatin
20. Unsweetened canned apricots
21. Blended citrus juice
22. **Potato soup**
23. **Crisp crackers**
24. **Broiled lamb patties—half pear with currant jelly**
25. Broiled lamb patties
26. Broiled lamb patties
27. Brown rice
28. **Green peas**
29. **Raw vegetable salad bowl**
30. **Russian dressing**
31. **Raspberry sherbet**
32. Canned peaches
33. Baked custard
34. Fresh pineapple
35. Grape juice
36. **Bread**

May 8

1. **Fresh pineapple**
2. Grapefruit juice
3. **Oatmeal or corn flakes**
4. **Poached egg**
5. Crisp bacon
6. **Toast**
7. **Beef bouillon**
8. **Crisp crackers**
9. **Baked breaded veal cutlet**
10. Baked veal chop
11. **Baked noodles**
12. Noodles
13. **Quartered carrots**
14. Quartered carrots
15. **Mixed green salad**
16. **Herb dressing**
17. **Orange floating island**
18. Orange floating island
19. Orange ice
20. Diced orange cup
21. Grapefruit juice
22. **Cream of celery soup**
23. **Saltines**
24. **Scrambled eggs with link sausages**
25. Chicken livers
26. Chicken livers
27. Baked potato
28. **Green beans**
29. **Sliced tomato salad**
30. **French dressing**
31. **Royal Anne cherries**
32. Royal Anne cherries
33. Floating island
34. Unsweetened canned Royal Anne cherries
35. Apricot nectar
36. **Bread**

May 9

1. **Grapefruit juice**
2. Apricot nectar
3. **Corn soya or hominy**
4. **Soft cooked egg**
5. Crisp bacon
6. **Whole wheat date muffins**
7. **Essence of celery soup**
8. **Melba toast**
9. **Baked shad with roe or halibut**
10. Broiled halibut
11. **Savory stuffed baked potato**
12. Baked potato
13. **Fresh spinach**
14. Fresh spinach
15. **Head lettuce salad**
16. **Thousand Island dressing**
17. **Strawberry shortcake**
18. Creamy rice pudding
19. Strawberry gelatin
20. Fresh strawberries
21. Blended citrus juice
22. **Cream of tomato soup**
23. **Croutons**
24. **Cheese dreams**
25. Fluffy omelet—asparagus
26. Fluffy omelet—asparagus
27. Parsley potato balls
28. ———
29. **Shredded cabbage, carrot and green pepper salad**
30. **Tarragon dressing**
31. **Baked cherry rhubarb—peanut butter cookies**
32. Orange sections
33. Chocolate rennet-custard
34. Orange slices
35. Pineapple juice
36. ———

May 10

1. **Sliced banana**
2. Orange juice
3. **Brown granular wheat cereal or puffed rice**
4. **Scrambled egg**
5. Grilled Canadian bacon
6. **Toast**
7. **Barley soup**
8. **Saltines**
9. **Braised beef chuck**
10. Braised beef chuck
11. **Franconia potatoes**
12. Parsley potatoes
13. **Harvard beets**
14. Latticed beets
15. **Cucumber and romaine salad**
16. **Parisian dressing**
17. **Baked custard with chocolate chips**
18. Baked custard
19. Pineapple whip
20. Unsweetened canned pear
21. Lemonade
22. **Beef noodle soup**
23. **Crisp crackers**
24. **Chicken a la king on rice**
25. Creamed chicken
26. Cold sliced chicken
27. Boiled rice
28. **Green peas**
29. **Grapefruit and red apple salad**
30. **French dressing**
31. **Oatmeal cookies**
32. Pear in cherry gelatin
33. Baked custard
34. Unsweetened canned peaches
35. Fruitade
36. **Bread**

May 11

1. **Blended citrus juice**
2. Blended citrus juice
3. **Wheat flakes or oatmeal**
4. **Soft cooked egg**
5. Crisp bacon
6. **Coffee cake**
7. **Beef broth**
8. **Toast sticks**
9. **Baked ham with cherry sauce**
10. Roast lamb
11. **Watercress new potatoes**
12. New potatoes
13. **French-style green beans**
14. French-style green beans
15. **Relish plate—sweet gherkins, radishes, olives**
16. ———
17. **Butter pecan ice cream**
18. Canned peaches with raspberry ice
19. Raspberry ice
20. Unsweetened canned fruit compote
21. Grapefruit juice
22. **Vegetable soup**
23. **Saltines**
24. **Banana bread cream cheese sandwiches**
25. Cottage cheese and pear salad—asparagus
26. Cottage cheese—asparagus
27. Baked potato
28. ———
29. **Orange, fresh pineapple and strawberry salad**
30. **Fruit salad dressing**
31. **Chocolate angel food**
32. Chocolate angel food
33. Vanilla blanc mange
34. Unsweetened canned plums
35. Tomato juice
36. ———

May 12

1. **Grapefruit**
2. Grapefruit juice
3. **Rolled wheat or crisp rice cereal**
4. **Poached egg**
5. Crisp bacon
6. **Toast**
7. **Consomme**
8. **Crisp crackers**
9. **Roast leg of veal**

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QUAKER ENRICHED FARINA

Why take the time to prepare two or three different kinds of cereals for patients of varying age groups? Quaker Enriched Farina, made of the finely granulated "heart" of the wheat kernel, is as ideal for older folks as it is for infants.

What's more, Farina's extra added values of Vitamins D, B_1 and B_6, plus Niacin, Iron and Calcium, give each patient an important share of his minimum daily requirements of these elements.

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★ ★ ★

save this recipe

FOR VARIETY—

Add any one of the following to cooked Farina:

a. chopped dates or dried figs
b. cooked dried apricots or prunes
c. semi-sweet chocolate chips

Serve Farina with any one of the following toppings:

a. place one tablespoon cherry or other preserves on each serving
b. sweetened fresh or frozen berries on top of each serving
c. sliced fresh or cooked peaches over each serving

Quantity Recipe for QUAKER FARINA

50 Servings — **Portion—¾ cup (6 to 7 oz.)**

INGREDIENTS	AMOUNT	WEIGHT	COST
Water	**2 gallons hot water 2 quarts cold water**		
Salt	**3 tablespoons**		
Farina	**2 quarts**	**3 lb.**	

DIRECTIONS

1. Add salt to hot water. Heat to boiling.
2. When water comes to a boil, combine Farina with the 2 quarts of *cold water;* add mixture to boiling salted water, stirring constantly. (For variety, use half or all milk instead of water.)
3. Cook, stirring frequently, 5 to 10 minutes.

THE QUAKER OATS COMPANY — CHICAGO 54, ILLINOIS

10. Roast leg of veal
11. **Mashed potatoes**
12. Riced potatoes
13. **Broccoli**
14. Acorn squash
15. **Apricot and stuffed date salad**
16. **Cream mayonnaise**
17. **Glorified rice**
18. Glorified rice
19. Lime gelatin
20. Orange slices
21. Apricot and lemon nectar

22. **Cream of tomato soup**
23. **Melba toast**
24. **Chopped beef and mushrooms on toast**
25. Chopped beef patties
26. Chopped beef patties
27. Paprika quartered potatoes
28. **Whole carrots**
29. **Crisp greens and radish salad**
30. **Poppy-seed sweet dressing**
31. **Canned pears**
32. Canned pears
33. Floating island
34. Fresh strawberries
35. Apple juice
36. **Bread**

May 13

1. **Orange juice**
2. Orange juice
3. **Corn flakes or brown granular wheat cereal**
4. **Scrambled egg**
5. Chicken livers
6. **Toast**

7. **Alphabet soup**
8. **Saltines**
9. **Beef and vegetable stew**
10. Hot beef cubes or braised liver
11. **Potato cubes** (in stew)
12. Potato cubes
13. **Whole kernel corn**
14. Green peas
15. **Tomato and cress salad**
16. **Blue cheese dressing**
17. **Banana cream pie**
18. Banana cream pudding
19. Cherry sponge
20. Fresh pineapple
21. Grapefruit juice

22. **Chicken okra soup**
23. **Crisp crackers**
24. **Ham and cornbread shortcake**
25. Veal and noodle casserole
26. Cold roast veal
27. Baked noodles (omit on Soft Diet)
28. **Green beans**
29. **Fresh fruit salad**
30. **French dressing**
31. **Peppermint stick ice cream**
32. Royal Anne cherries
33. Peppermint stick ice cream
34. Unsweetened canned bing cherries
35. Pineapple juice
36. ———

May 14

1. **Grapefruit**
2. Grapefruit juice
3. **Hominy or shredded wheat**
4. **Soft cooked egg**
5. Grilled sausages
6. **Whole wheat raisin toast**

7. **Tomato bouillon**
8. **Crisp crackers**
9. **Roast pork with dressing**
10. Roast lamb
11. **Green Lima beans**
12. Boiled rice
13. **New beets with tops**
14. Sliced beets
15. **Pepper relish salad**
16. ———
17. **Rhubarb cobbler**
18. Bread pudding
19. Lemon and lime gelatin cubes
20. Unsweetened canned pear
21. Blended citrus fruit

22. **Puree of split pea soup**
23. **Saltines**
24. **Cheese souffle**
25. Cheese souffle
26. Broiled steak
27. Latticed potatoes
28. **Fresh asparagus**
29. **Tossed salad**
30. **Vinegar-oil dressing**
31. **Cup cakes with chocolate nut frosting**
32. Applesauce
33. Baked custard
34. Unsweetened canned peaches
35. Orange juice
36. **Toast—grape jelly**

May 15

1. **Fresh strawberries**
2. Apricot nectar with lemon
3. **Bran flakes or farina**
4. **Poached egg**
5. Crisp bacon
6. **Bacon muffins**

7. **Julienne vegetable soup**
8. **Saltines**
9. **Baked chicken loaf—spiced apricot**
10. Hot sliced chicken
11. **Parsley creamed new potatoes**
12. New potatoes
13. **Green beans**
14. Green beans
15. **Paprika celery curls**
16. ———
17. **Raspberry sherbet**
18. Raspberry sherbet
19. Raspberry ice
20. Unsweetened canned bing cherries
21. Lemonade

22. **Cream of asparagus soup**
23. **Croutons**
24. **Cold sliced tongue—potato salad—sliced tomatoes**
25. Minced lamb—peas
26. Cold roast lamb—peas—tomato salad
27. Fluffy potatoes
28. ———
29. ———
30. ———
31. **Peaches and rice cream**
32. Rice with sliced peaches
33. Soft custard
34. Diced orange cup
35. Cherry juice
36. **Parker House rolls**

May 16

1. **Orange halves**
2. Orange juice
3. **Rolled wheat or corn flakes**
4. Scrambled egg (omit on Normal Diet)
5. Crisp bacon
6. **Griddle cakes—syrup**

7. **Cream of celery soup**
8. **Melba toast**
9. **Fried scallops—tartar sauce**
10. Broiled haddock fillets
11. **Mashed potatoes**
12. Riced potatoes
13. **Sliced carrots**
14. Sliced carrots
15. **Cabbage and toasted almond salad, pimiento garnish**
16. **Sour cream dressing**
17. **Cottage pudding with cherry sauce**
18. Cottage pudding with cherry sauce
19. Whipped strawberry gelatin
20. Unsweetened canned plums
21. Grapefruit juice

22. **Shrimp bisque**
23. **Crisp crackers**
24. **Egg salad sandwich**
25. Creamed tuna—asparagus
26. Low fat tuna—acorn squash
27. Baked potatoes
28. ———
29. **Asparagus and beet salad**
30. **Russian dressing**
31. **Fresh fruit cup**
32. Canned fruit cup
33. Vanilla blanc mange with cherry juice
34. Fresh fruit cup
35. Apricot juice
36. ———

May 17

1. **Grapefruit juice**
2. Grapefruit juice
3. **Crisp rice cereal or oatmeal**
4. **Poached egg**
5. Grilled sausages
6. **Toast**

7. **Consomme**
8. **Whole wheat wafers**
9. **Broiled ham slice**
10. Broiled lamb pattie
11. **Scalloped potatoes**
12. Parsley lattice potatoes
13. **Hot wilted greens**
14. Mashed squash
15. **Peach, chopped date and nut salad**
16. **Cream mayonnaise**
17. **Coconut snow pudding with custard sauce**
18. Lemon snow pudding with custard sauce
19. Lemon snow pudding
20. Unsweetened canned Royal Anne cherries
21. Lemonade

22. **Old-fashioned potato soup**
23. **Saltines**
24. **Beef cubes with noodles**
25. Beef cubes with noodles—peas
26. Beef cubes—peas
27. Baked noodles (omit on Soft Diet)
28. ———
29. **Raw spinach, lettuce and radish salad**
30. **Vinegar-oil dressing**
31. **Fresh pineapple shortcake**
32. Canned peeled apricots
33. Raspberry rennet-custard
34. Fresh pineapple
35. Orange juice
36. **Bread**

May 18

1. **Sliced banana**
2. Blended citrus juice
3. **Brown granular wheat cereal or wheat flakes**
4. **Scrambled egg**
5. Crisp bacon
6. **Toast**

7. **Noodle soup**
8. **Saltines**
9. **Roast chicken with dry dressing**
10. Roast chicken
11. **Mashed potatoes**
12. Riced potatoes
13. **Fresh asparagus**
14. Fresh asparagus
15. **Jellied fruit salad**
16. **Fruit salad dressing**
17. **Chocolate ice cream**
18. Chocolate ice cream
19. Cranberry ice (no cream)
20. Unsweetened canned peaches
21. Orange juice

22. **Cream of celery soup**
23. **Crisp crackers**
24. **Open faced lettuce, tomato and bacon sandwich**
25. Egg halves on spinach with cheese sauce
26. Broiled veal steak—spinach—tomato salad
27. Baked potato
28. ———
29. ———
30. ———
31. **Pear, apricot and cherry compote—macaroons**
32. Royal Anne cherries
33. Vanilla ice cream
34. Unsweetened canned pears
35. Fruitade
36. ———

May 19

1. **Orange juice**
2. Orange juice
3. **Bran flakes or hominy**
4. **Soft cooked egg**
5. Broiled ham
6. **Toast**

7. **Beef bouillon**
8. **Crisp crackers**
9. **Lamb chop grill, bacon, broiled tomato**
10. Broiled lamb chop
11. **Parsley buttered potatoes**
12. New potatoes
13. ———
14. Green peas
15. **Mixed green salad**
16. **Chiffonade dressing**
17. **Rhubarb meringue pie**
18. Pineapple whip
19. Pineapple whip
20. Unsweetened canned fruit cocktail
21. Blended citrus juice

22. **Cream of spinach soup**
23. **Croutons**
24. **Tuna roll-ups with mushroom sauce**
25. Escalloped tuna
26. Cold sliced chicken
27. Parsley cubed potatoes
28. **Sliced carrots**
29. **Cucumber and pimiento salad**
30. **French dressing**
31. **Fresh strawberries**
32. Canned fruit gelatin
33. Baked custard
34. Fresh strawberries
35. Grapefruit juice
36. **Bread**

May 20

1. **Grapefruit**
2. Prune juice with lemon
3. **Rolled wheat or crisp rice cereal**
4. **Scrambled egg**
5. Crisp bacon
6. **Cinnamon toast**

7. **Consomme with custard cubes**
8. **Saltines**
9. **Corned beef with mustard sauce**
10. Pot roast of beef
11. **Boiled potatoes**
12. Boiled potatoes
13. **Green cabbage wedge**
14. Wax beans
15. **Tomato aspic salad**
16. **Mayonnaise**
17. **Floating island**
18. Floating island
19. Grape sponge
20. Fresh pineapple
21. Orange juice

22. **Cream of asparagus soup**
23. **Crisp crackers**
24. **Welsh rarebit on toast**
25. Welsh rarebit on toast
26. Cold corned beef
27. Stuffed baked potato
28. **Spinach**
29. **Sliced orange salad**
30. **Paprika French dressing**
31. **Lady Baltimore cake**
32. Canned fruit cup
33. Floating island
34. Unsweetened canned plums
35. Grape juice
36. **Bread**

May 21

1. **Orange juice**
2. Orange juice
3. **Corn flakes or oatmeal**
4. **Poached egg**
5. Crisp bacon
6. **Toast**

7. **Cream of pea soup**
8. **Croutons**
9. **Country style liver**
10. Pan-broiled liver
11. **Potatoes au gratin**
12. Cubed potatoes
13. **Spiced beets**
14. Sliced beets
15. **Lettuce and cress salad**
16. **Green Goddess dressing**
17. **Pineapple upside-down cake**
18. Chocolate pudding
19. Lime gelatin
20. Half grapefruit
21. Blended citrus juice

22. **Noodle soup**
23. **Saltines**
24. **Spoon bread—Canadian bacon**
25. Crisp bacon
26. Broiled beef patties
27. Riced potatoes
28. **Fresh asparagus**
29. **Grapefruit and sliced strawberry salad**
30. **Clear French dressing**
31. **Rice with whipped cream, caramel pecan sauce**
32. Rice and tinted pear compote
33. Chocolate pudding
34. Unsweetened canned Royal Anne cherries
35. Apricot juice
36. **Bread**

May 22

1. **Banana and fresh pineapple**
2. Blended citrus juice
3. **Farina or wheat and barley kernels**
4. **Soft cooked egg**
5. Crisp bacon
6. **Coffee cake**

7. **Consomme**
8. **Toast sticks**
9. **Pot roast of beef Philadelphia relish**

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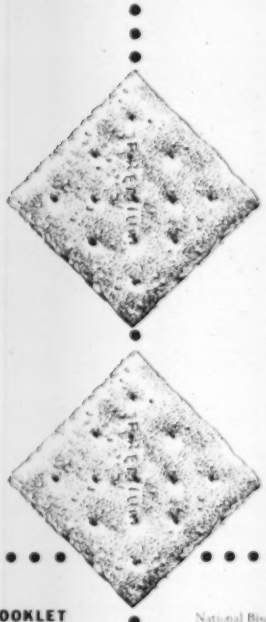

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You can roast, bake and do general oven cookery in a Blodgett oven because of its flexibility and large capacity. Each section is separately controlled for proper heat. Foods requiring different temperatures are cooked in different decks at the same time; in one section, meat is roasted at low temperature, 300°F., thus preventing excess meat shrinkage and providing more servings per pound; in another, appetizing, high quality pies, muffins and biscuits can be baked at 425°F.; while scalloped dishes, casseroles and meat pies are cooked in still another at 350°F.

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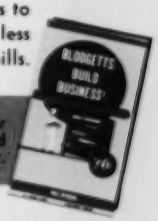

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TYPICAL PATCH TEST

Over 400 infants and children from 2 weeks to 6 years of age acted as test subjects to check the incidence of sensitivity to orange juice. After 2 to 12 months' observation,* "no disturbance of bowel function (diarrhea or constipation) that could be attributed to the orange juice" was found. Also, the occurrence of regurgitation and rashes was "minimal". In the rare instances of sensitivity, care exercised by gentle reaming of juice (or the use of frozen concentrate) to avoid contamination with peel oil usually obviates the difficulty.

**J. Pediat. 39:325, 1951*

FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

FLORIDA *Citrus*

ORANGES • GRAPEFRUIT • TANGERINES

10. Pot roast of beef
11. **Boiled rice**
12. Boiled rice
13. **Glazed carrots**
14. Whole carrots
15. ———
16. ———
17. **Strawberry sundae**
18. Vanilla ice cream
19. Fruit ice
20. Fresh strawberries
21. Grapefruit juice
22. **Cream of mushroom soup**
23. **Crisp crackers**
24. **Macaroni and cheese en casserole**
25. Macaroni and cheese
26. Broiled lamb cutlet
27. Potato balls (omit on Soft Diet)
28. **French-style green beans**
29. **Quartered tomato and parsley salad**
30. **Thousand Island dressing**
31. **Chocolate eclairs**
32. Canned peaches
33. Vanilla ice cream
34. Unsweetened canned peaches
35. Orange juice
36. **Whole wheat rolls**

May 23

1. **Grapefruit juice**
2. Grapefruit juice
3. **Puffed rice or brown granulated wheat cereal**
4. Scrambled egg (omit on Normal Diet)
5. Crisp bacon
6. **Griddle cakes—syrup**
7. **Cream of vegetable soup**
8. **Saltines**
9. **Salmon loaf with parsley cream sauce**
10. Broiled salmon steak
11. **Potato croquettes**
12. Parsley potatoes
13. **Fresh asparagus**
14. Fresh asparagus
15. **Tossed lettuce, celery and orange salad**
16. **French dressing**
17. **Blueberry cake squares with blueberry sauce**
18. Baked custard with apricot puree
19. Raspberry gelatin
20. Fresh blueberries
21. Orange juice
22. **Clam chowder**
23. **Oyster crackers**
24. **Omelet**
25. Omelet
26. Omelet
27. Baked potato
28. **Green peas**
29. **Celery hearts**
30. ———
31. **Canned prune plums**
32. Royal Anne cherries
33. Baked custard
34. Unsweetened canned fruit cocktail
35. Pineapple juice
36. **Butterscotch pecan rolls**

May 24

1. **Sliced orange**
2. Orange juice
3. **Rolled wheat or corn flakes**
4. **Soft cooked egg**
5. Crisp bacon
6. **Toast**
7. **Beef broth**
8. **Crisp crackers**
9. **Baked Canadian bacon**
10. Baked veal loin
11. **Candied sweet potatoes**
12. Noodles
13. **Swiss chard or broccoli**
14. Mashed squash
15. **Apricot au natural salad**
16. **Cream mayonnaise**
17. **Banana lemon gelatin, whipped cream**
18. Banana lemon gelatin, whipped cream
19. Lemon gelatin
20. Fresh pineapple
21. Grapefruit juice
22. **Cream of corn soup**
23. **Saltines**
24. **Chopped beef patties with mushroom sauce**
25. Broiled beef patties
26. Broiled beef patties
27. Parsley potato balls
28. **Julienne carrots**
29. **Head lettuce salad**
30. **Russian dressing**
31. **Fresh fruit cup**
32. Canned fruit cocktail
33. Raspberry rennet-custard
34. Unsweetened canned loganberries
35. Blended citrus juice
36. **Hot rolls**

May 25

1. **Tomato juice**
2. Tomato juice
3. **Shredded wheat or farina**
4. **Poached egg**
5. Grilled sausages
6. **Sweet rolls**
7. **Orange juice with ginger ale**
8. ———
9. **Fried chicken with cream gravy**
10. Roast chicken
11. **Mashed potatoes**
12. Riced potatoes
13. **Green peas**
14. Green peas
15. **Spiced prunes on cress with chopped pistachio nuts**
16. ———
17. **Raspberry royal ice cream**
18. Cranberry ice
19. Lime ice
20. Fresh strawberries
21. Beef bouillon
22. **Cream of vegetable soup**
23. **Melba toast**
24. **Fresh asparagus on toast with thin cheese sauce**
25. Asparagus on toast with cheese sauce
26. Baked veal chop—asparagus
27. Baked potato
28. ———
29. **Tossed tomato, lettuce and celery salad**
30. **Herb French dressing**
31. **Angel food cake with strawberries, whipped cream**
32. Canned peeled apricots—angel food
33. Maple custard
34. Unsweetened canned Royal Anne cherries
35. Fruitade
36. **Bread**

May 26

1. **Grapefruit**
2. Blended citrus juice
3. **Oatmeal or puffed wheat**
4. **Scrambled egg**
5. Crisp bacon
6. **Toast**
7. **Spun egg broth**
8. **Saltines**
9. **Baked pork chop**
10. Roast lamb
11. **Quartered potatoes in cream**
12. Steamed potatoes
13. **Stewed tomatoes**
14. Spinach with lemon
15. **Poppy-seed coleslaw on half slice pineapple**
16. ———
17. **Apple cobbler**
18. Grape sponge
19. Grape sponge
20. Unsweetened canned peaches
21. Orange juice
22. **Alphabet soup**
23. **Crisp crackers**
24. **Chow mein on rice—Chinese noodles**
25. Chicken and noodle casserole—carrots
26. Cold sliced chicken—carrots
27. Boiled rice
28. ———
29. **Green bean and pimiento salad**
30. **French dressing**
31. **Canned bing cherries**
32. Canned bing cherries
33. Cornstarch pudding
34. Unsweetened canned plums
35. Apricot nectar
36. **Hard rolls**

May 27

1. **Orange juice**
2. Orange juice
3. **Crisp rice cereal or brown granular wheat cereal**
4. Soft cooked egg (omit on Normal Diet)
5. Grilled sausages
6. **Cornmeal muffins—sausages**
7. **Jellied broth with lemon slice**
8. **Crisp crackers**
9. **Beef pie with pastry crust**
10. Broiled steak
11. ———
12. Parsley potatoes
13. **Cauliflower or beets**
14. Latticed beets
15. **Head lettuce salad**
16. **Russian dressing**
17. **Lemon milk sherbet with strawberry sauce**
18. Lemon milk sherbet
19. Lemon milk sherbet
20. Unsweetened canned pear
21. Grapefruit juice
22. **Cream of chicken soup**
23. **Croutons**
24. **Stuffed tomato with cottage cheese**
25. Cottage cheese on lettuce—green beans
26. Stuffed tomato with cottage cheese
27. Baked potato
28. ———
29. **Celery and radishes**
30. ———
31. **Fresh pineapple—chocolate cookies**
32. Canned peaches
33. Cherry gelatin
34. Fresh pineapple
35. Pear nectar
36. **Bran muffins**

May 28

1. **Banana**
2. Grapefruit juice
3. **Farina or bran flakes**
4. **Scrambled egg**
5. Crisp bacon
6. **Toast**
7. **Tomato bouillon**
8. **Saltines**
9. **Rolled stuffed veal steak**
10. Roast veal
11. **Mashed potatoes**
12. Fluffy potatoes
13. **Julienne carrots**
14. Julienne carrots
15. **Cucumber and romaine salad**
16. **French dressing**
17. **Jelly roll**
18. Jelly roll
19. Apricot nectar mold
20. Unsweetened canned Royal Anne cherries
21. Lemonade
22. **Cream of mushroom soup**
23. **Crisp crackers**
24. **Baked egg on corned beef hash**
25. Broiled beef patties—spinach
26. Broiled beef patties—spinach
27. Potato balls
28. ———
29. **Tomato and shredded cabbage salad**
30. **Tarragon dressing**
31. **Fresh blueberries**
32. Orange sections
33. Baked custard
34. Fresh blueberries
35. Blended citrus fruit
36. **Hot rolls**

May 29

1. **Fresh strawberries**
2. Tomato juice
3. **Puffed rice or rolled wheat**
4. **Poached egg**
5. Crisp bacon
6. **Toast**
7. **Vegetable soup**
8. **Crisp crackers**
9. **Roast leg of lamb or roast beef**
10. Roast leg of lamb
11. **New potatoes**
12. New potatoes
13. **Green peas**
14. Green peas
15. **Pear blush salad**
16. **Cream mayonnaise**
17. **Orange cream pudding with meringue**
18. Orange cream pudding with meringue
19. Orange ice
20. Orange sections
21. Grapefruit juice
22. **Scotch barley soup**
23. **Saltines**
24. **Creamed chicken on Southern cornbread—spiced peach**
25. Creamed chicken—asparagus tips
26. Hot sliced chicken—broiled tomato
27. Whipped potatoes
28. ———
29. **Tossed lettuce salad**
30. **Poppy-seed sweet dressing**
31. **Royal Anne cherries**
32. Royal Anne cherries
33. Cream pudding
34. Unsweetened canned fruit cocktail
35. Cranberry juice
36. **Bread**

May 30

1. **Sliced orange**
2. Orange juice
3. **Oatmeal or corn flakes**
4. **Soft cooked egg**
5. Crisp bacon
6. **Toast**
7. **Potato soup**
8. **Saltines**
9. **Golden crusted ocean perch—tartar sauce**
10. Broiled ocean perch
11. **Mashed potatoes**
12. Riced potatoes
13. **Green beans**
14. Green beans
15. **Perfection salad**
16. **Mayonnaise**
17. **Strawberry whipped cream pie**
18. Strawberry Bavarian
19. Raspberry gelatin
20. Fresh strawberries
21. Blended citrus juice
22. **Cream of pea soup**
23. **Toast sticks**
24. **Stuffed green peppers with tomato spaghetti, cheese sauce**
25. Cold poached salmon
26. Cold poached salmon
27. Potato souffle
28. **Sliced beets**
29. **Asparagus salad**
30. **Chiffonade dressing**
31. **Burnt sugar layer cake**
32. Canned peeled apricots
33. Floating island
34. Fresh pineapple
35. Grape juice
36. **Bread**

May 31

1. **Grapefruit**
2. Grapefruit juice
3. **Wheat flakes or brown granular wheat cereal**
4. **Scrambled egg**
5. Grilled sausages
6. **Raisin toast**
7. **Broth with mushrooms**
8. **Crisp crackers**
9. **Baked beef loaf**
10. Pan-broiled liver
11. **Potatoes au gratin**
12. Potato balls
13. **Baked or fried eggplant slices**
14. Spinach with lemon
15. **Quartered tomato salad**
16. **French dressing**
17. **Fruit ambrosia—vanilla wafers**
18. Boston cream pie
19. Cherry sponge
20. Unsweetened canned apricots
21. Orange juice
22. **Cream of asparagus soup**
23. **Saltines**
24. **Toasted ham sandwich—pickle chips**
25. Crisp bacon—peas
26. Baked veal chop—peas
27. Baked potato
28. ———
29. **Cabbage, red apple and celery salad**
30. **Sour cream dressing**
31. **Boston cream pie**
32. Canned fruit in raspberry gelatin
33. Chocolate pudding
34. Unsweetened canned fruit compote
35. Pineapple juice
36. ———

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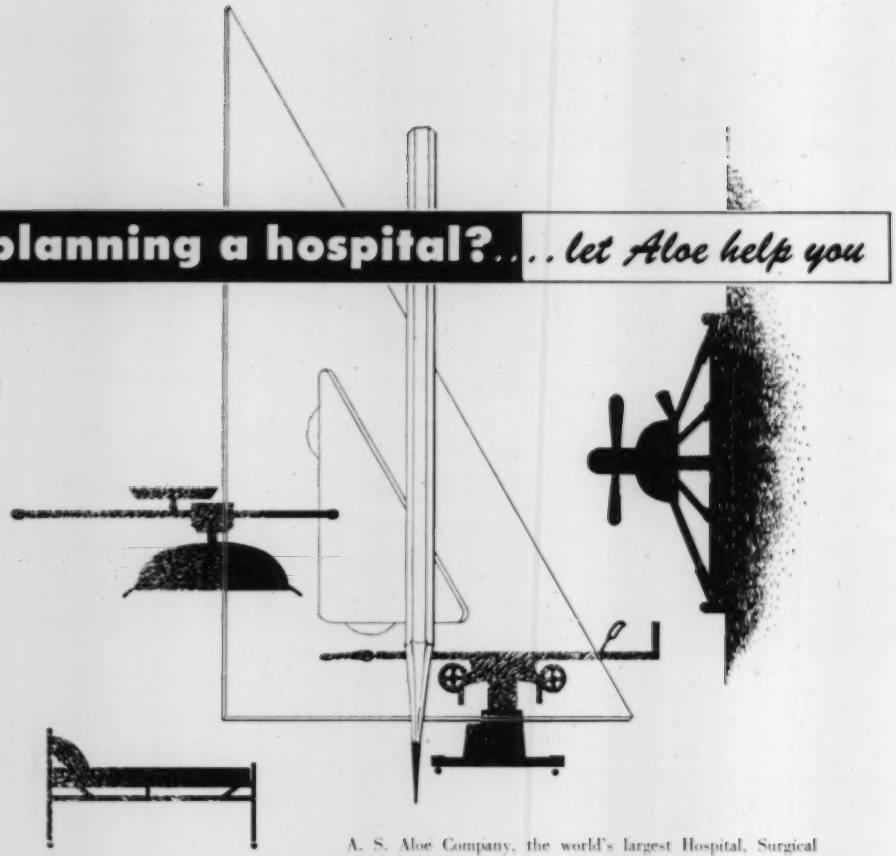

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Removing the ice problem as a source of complaint

ANDREW A. MILLER

THE PROCEDURE of delivering ice to our floors and pavilions from a central ice station formerly was a source of constantly recurring complaints.

We had a large ice storage bin in the basement with a capacity of about eight 300-pound cakes of ice. Our porter, after chopping the ice, would place it into an ice cart and make the rounds of the floors filling ice chests twice a day. In midsummer, he would make the trips more frequently.

Often, the ice supplier would be late in delivering to our institution. This usually occurred when the weather was extremely hot and humid and when our ice supply was dangerously low, if not completely exhausted. There were even a few times when the porter, while chopping the ice, would chop through the bottom of the storage bin, making a relining job necessary.

We would receive complaints from the floors that the pieces of ice were too large or too small—never just right. To get the ice in a uniform size, we persuaded the supplier to install a motor-driven chopper on his truck and to furnish us with pre-chopped ice.

This solved the size problem but we began receiving complaints from patients that the ice chopping operation was making too much noise and creating too great a disturbance. The supplier was then requested to chop the ice some distance away from the premises and to deliver the cracked ice in tubs.

This system seemed to take care of the size of the ice and the chopping disturbance, but we discovered that we were paying more and more for less and less ice. The Mount Vernon (N. Y.) Hospital has 220 beds and uses an average of 75,000 pounds of ice a month which, at 33 cents per hundredweight, costs about $250 a month. Furthermore, the porter who termed himself a "specialist" in his field demanded and received a few dollars more than the average hospital porter. So, actually, we were spending more than $350 a month on our ice supply and distribution.

Convinced that we would have to install our own equipment, we began to survey the ice-making field. Eventually we found the very machine we had been so diligently seeking. The apparatus is an electric refrigerator cabinet measuring about 20 x 38 x 40 inches. It contains a rapid freezing area which holds 20 trays, each tray having a 16-cube divider. The total capacity of the machine is 320 ice cubes. This compartment has an insulated door which opens outward, the same as any household refrigerator door.

Next to this compartment is a storage space for the storing of

THE electric refrigerator cabinet has a freezing area which holds 20 ice cube trays in addition to a large storage space. The machine makes 250 pounds of ice every 24 hours.

Mr. Miller is assistant director of the Mount Vernon (N. Y.) Hospital.

fully formed and frozen ice cubes and this is equipped with a door which opens forward and down on a hinge. The enameled top of the cabinet can be used as a table top. The machine has a capacity of making 250 pounds of ice cubes every 24 hours. The ice cube trays are the same as those found in a household refrigerator.

We purchased one of these machines in December 1949 on a trial basis and installed it in the serving kitchen of the floor having the heaviest calls for ice. Two months later, we ordered nine more of the machines and placed one in the serving kitchen of each pavilion of the hospital; one in the main kitchen for dietary use, and one in the basement corridor for both dietary, auxiliary and general use.

The installation and operation of these machines has eliminated all of the complaints, annoyances, and inconveniences, as well as abolishing the ice-porter's job. We are now assured of having clean and uniform sized ice available on all of the floors at all times. The cost of the water and electric current for the operation is a very small fraction of what we formerly paid for ice supply and distribution. The ice problem, as far as we are concerned, has been solved to everyone's satisfaction.

The Purchasing department is edited by Leonard P. Goudy, purchasing specialist.

Purchasing Comment

Scrap drive

THE MOST serious problem confronting the defense production program today is the shortage of iron and steel scrap. The need of the steel mills and foundries for scrap has become so critically urgent that no effort can be spared which will produce a pound of scrap. Almost every industry or business has dormant scrap which can be turned into the channels leading to the steel mills and foundries of the country.

Tons and tons of high alloy steel, brass, and chrome plate are lying useless in many hospitals. An excellent scrap source—and one which is likely to be overlooked—can be found in the form of idle medical gas cylinders and the valves with which they are equipped. If this source is directed into the proper channels, large supplies of vital metals would become available again for the manufacture of new cylinders and valves to meet the ever-increasing demand.

There is a strong possibility that a concerted effort in hospitals to ferret out unused metals would bring to light unnoticed fire hazards and other unsafe conditions. Many unemployed dollars of inventory would be released for better use.

In one hospital, for example, an administrator thought his cylinder stocks were being handled effi-

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No more complaints on charges for O_2 therapy—The And-O-Meter registers the exact amount used.

No more losses on O_2 therapy—The And-O-Meter charted readings determine the billing.

No more guess work—Accurate records of the oxygen dispensed permit charges equitable to both the hospital and the patient.

Scientifically accurate—The And-O-Meter readings of actual amounts of oxygen used, continuously or intermittently, are accurate guides to charges for the oxygen dispensed.

Dependably versatile—The And-O-Meter can be used with all types of oxygen therapy, regardless of whether the tank is in the room or the oxygen is piped in from a central source of supply.

Easy to install—The slip-on hose connection and universal bracket are designed to fit all standard sizes of tubing.

Simple to use—The And-O-Meter dial reading is marked on an oxygen chart every eight hours. These charts serve as permanent records of the volume of oxygen used by each patient.

Convenient to compute—An automatic calculator is furnished which converts the charted readings to liters of oxygen used, for easy cost accounting.

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ciently until he received a complaint of an accumulation of empty cylinders in a washroom. He ordered a search of the entire building and as a result and at an estimated cost of five man-hours, his inventory was reduced by more than $1,000. New storage and floor space was made available as a result of the investigation. A hazardous method of storing cylinders was promptly corrected. Responsibility for the inventory was instituted and a control system established to prevent a recurrence.

Some examples of the places where cylinders have been found in hospitals are:

- Nine dust-covered crates filled with empty cylinders were found in a general storage room behind cartons which had been stacked to the ceiling.
- In one hospital, three large cylinders were being used as hat and coat racks.
- Another hospital checked its records to find that several cylinders had been loaned to staff doctors who had overlooked returning them.
- Two crates of six full cylinders each were found in one hospital's morgue.

Many cylinders have been found attached to old anesthetic machines which had been stored away in maintenance departments, attics, and closets. Some cylinders have been removed from little-used anesthetic machines still equipped with a full complement of cylinders.

An exhaustive search conducted by hospitals throughout the country is certain to unearth tons of scrap in the form of old machinery parts, worn-out boilers, unused or obsolete surgical and maintenance tools. In turning these over to the national scrap campaign, the hospitals will have fulfilled their role in the defense program.

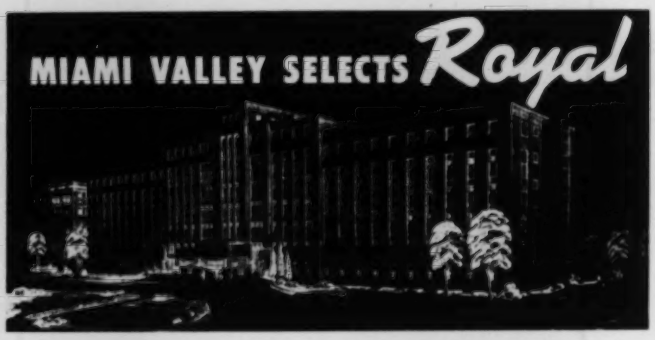
DDT substitute

During World War II and the post-war period, dramatic results were obtained by the use of DDT as an insecticide. DDT, with or without the addition of chlordane, was very effectively used by hospitals in the control of cockroaches, silverfish and other insects. Present results, however, especially from use in the Korean campaign, would seem to indicate that many common insects have developed resistance to DDT.

It is our good fortune that science is able to keep pace with such developments and bring forth new products. It now appears that members of the benzene hexachloride family have been developed as very satisfactory substitutes and may even have a wider range of effectiveness. (3 P-1)*

If a hospital's program of vermin control does not appear to be as effective as in the past, it could be that the premises are infested by resistant strains and that a change to one of the newer chemicals would be helpful.

*For the name and address of the manufacturer, write the Editorial Department, HOSPITALS, 18 E. Division Street, Chicago 10. For convenience, please use the code number referred to.



New Dayton, Ohio, hospital specifies six different Royal communicating and radio systems

How many patient and personnel problems can be solved with proper radio and communication systems? Those responsible for the design and construction of this 500-bed hospital — Architect: Schenk & Williams; Consultant: Dr. Christopher Parnall; General Contractor: Maxon Construction Co.—found six in all; agreed on Royal equipment exclusively.

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—reports Indianapolis Methodist Hospital

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HOSPITAL ARCHITECTS, CONTRACTORS: See new and complete EDISON TELEVOICE catalog in the latest Sweet's Architectural File--Section 32.

DOCTORS LIKE AND USE TELEVOICE!

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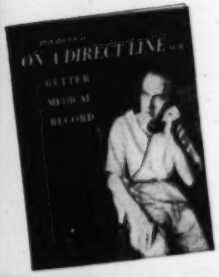
EDISON TELEVOICEWRITER

The Televoice System



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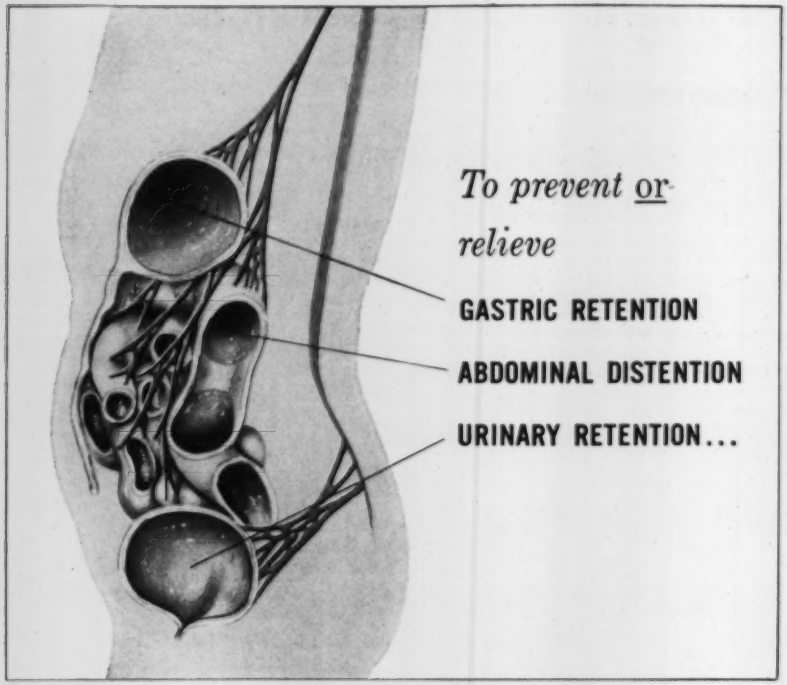

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Index of hospital literature is invaluable reference

THE FUNCTION OF a special library is not limited to the acquisition and proper classification of printed material. The library has an additional responsibility: To keep its clientele informed about what has been written and to index the current periodical literature so that it is available for use.

The Library of the American Hospital Association fulfills this responsibility by the preparation and publication of the semiannual Index of Current Hospital Literature. Since the first issue was printed in 1945, subscribers have been receiving the Index every February and August. In one alphabetical listing may be found both the subject and author of all articles dealing with hospital administration. These articles are found in some 150 journals.

The Index may be used for three specific purposes:

1. To locate a particular article that had been read once or to which a specific reference had been made.
2. To prepare complete or selective bibliographies on a given topic as a basis for study on that subject.
3. To become acquainted with what is being written in the field and to stimulate further reading.

The Index, therefore, is of help not only to a librarian or a secretary, but also of direct interest to an administrator or a department head. For example, in the Index for the first half of 1951, there were 16 references to hospital laundry operation and management.

Many journals are received in the Library and are read thoroughly for articles dealing with hospitals. Because the Library does subscribe to these periodicals in allied fields, the Index's coverage is essentially complete. For articles in periodicals to which the Library does not regularly subscribe, the staff searches the specialized indexes in these related fields and obtains copies of any articles concerning hospitals. For instance, if the Industrial Index lists an article on hospital lighting in the journal Illuminating Engineering, the article is requested, indexed, and the clipping is added to the vertical files. The Index, therefore, carries not only listings for articles appearing in hospital journals but also attempts to cover all the periodical literature.

The hospital that has an administrative library and keeps files of the journals to which it subscribes can use the Index to make better use of these journals. It is also possible to refer to the Index when requesting material on loan from the Library of the American Hospital Association. Complete bibliographic information is given for each article listed—the full title, author, name of journal, date and paging. As an illustration, an article on nurse recruitment appears twice in the Index. One listing is under the author's name: Rourke, Anthony J. J. Steps toward success in recruitment of nurses. HOSPITALS. 25:66, Feb. 1951. The other listing is under the subject *Nurses and Nursing-Recruitment*.

There is now available a Cumulative Index for the years 1945 through 1949. It brings together in one listing the articles indexed in the single issues for the five-year period. It is the Library's plan to cumulate the next five years into a single volume also, making reference to the single semiannual issues unnecessary.

The Index is invaluable as an administrative tool for more intelligent use of the current periodical literature. It is a reference source that is as helpful to the small hospital with a small library as it is to the library of a university offering a graduate course in hospital administration.

Subscription price for the two issues of the Index is $3 a year. The Cumulative Index for the years 1945 through 1949 is $5.

Inquiries about books reviewed in the Literature department should be addressed to the American Hospital Association Library — Asa S. Bacon Memorial, 18 E. Division Street, Chicago 10. The department is edited by Helen V. Pruitt, librarian.

Medical records manual

MANUAL FOR MEDICAL RECORDS LIBRARIANS. Third edition revised. Edna K. Huffman. Chicago. The Physicians Record Company. 1952. 512 p. $7.50.

Since the publication of the first edition of Mrs. Huffman's manual, record librarians have had a helpful source of information and guidance. With the revisions, this edition is of even greater assistance not only to the trained and experienced medical record librarian but also to the inexperienced librarian. As its name implies, the book is a real "manual" and can be used for understanding the functions and responsibilities of the medical record department and then as a day-to-day guide when problems arise.

A major portion of the second edition has been completely rewritten to bring the material up to date. The chapter on the medical record, its analysis and use, has been rewritten entirely, as well as the section on organization and management of the department. In the latter section a new feature is a series of job descriptions for the various tasks assumed by medical record personnel.

Because the Standard Nomenclature of Diseases and Operations has been revised, the chapter on standards in this manual also has been revised. It gives the medical record librarian an introduction to the construction and use of code

numbers. After the section on standards, there is an explanation of the International Statistical Classification and its use in the compilation of statistical data.

With the increasing emphasis on the medical audit in the hospital and the importance of the medical record in preparing the medical audit, there is an entirely new chapter on the responsibility of the medical record librarian for this important job of professional accounting.

Mrs. Huffman has had wide experience in teaching as well as in actual work as a medical record librarian. It is because of her skill in interpreting the materials for teaching that her text has always been a standard guide for medical record librarians. The hospital administrator who has read through the manual at least once will have a much clearer conception of the results he expects this department to produce in his hospital. It will provide him with a useful guide in evaluating the work of the medical record personnel. The manual also may be used to teach the importance and the use of medical records to medical students.

Because Mrs. Huffman has written her book so clearly and has used so many examples, illustrations and forms, there can be little doubt left in the mind of the medical record librarian about proper procedures. This edition will find its way into every hospital medical records department. The author is to be commended for yet another contribution to literature in the field of medical records library science.

Standard nomenclature guide

TEXTBOOK AND GUIDE TO THE USE OF THE STANDARD NOMENCLATURE. Adaline C. Hayden. Chicago. Physicians Record Company. 1952. 630 p. $8.

In January the first revision of the Standard Nomenclature of Diseases and Operations since 1942 was made available to hospitals. There have been considerable changes which have allowed for the progress in medicine and which have clarified some of the coding of the earlier editions. Mrs. Hayden, a former associate editor of the Standard Nomenclature and for many years active in medical record library science, has prepared a companion volume which will make the standard much easier to use by the average medical record librarian.

Much of the material in the textbook was prepared for presentation at the various institutes conducted cooperatively by the American Hospital Association and the American Association of Medical Record Librarians. At the recent institutes, half of the week's curriculum was devoted to a discussion of the standard and practice in its use. The lectures were given by Mrs. Hayden and have been of much help to the practicing librarian.

The book is arranged to orient the new record librarian—and refresh the memory of the expeperienced one—with the history of the standard nomenclature, its basic principles and scheme, including the topographic classifications and the ideologic classifications. Chapter III discusses the various classifications in detail; for example, the hemic and lymphatic systems and the reclassification of fractures. The fourth chapter outlines the construction of the nomenclature in its arrangement and highlights the alphabetic alignment in the indentations. There is a special section on the use of the letter "y" in the coding. The next three chapters discuss the three schemes that have had the greatest amount of change—the psychobiologic unit, the hemic and lymphatic systems, and the tumor classification. There is a practical chapter on the installation of the standard with all the information that a record librarian would need in the preparation of the indexed cards, the code number alignment, date of installation, the support of the medical staff and equipment.

Tables of diseases and code numbers listed in the third edition with cross reference to the code numbers and diagnoses listed in the fourth edition are found in Chapters V, VI and VII.

Because of the need for some knowledge of the international statistical classification and its correlation with the standard nomenclature, there are two chapters dealing with the composition of the international classification and its installation as supplemental to the standard. Special problems arising in the coding and cross indexing are given detailed treatment in three chapters. Included are the use of eponyms, fractures and dislocations, infection and infestation, and nondiagnostic terms for hospital records.

The entire second part of the textbook and guide treats disease service classification which lists by the 21 accepted services each disease coded in the standard nomenclature. This classification makes it possible for the record librarian to compile the statistics for the medical work done in the hospital according to the various services. In the small hospitals that do not have all 21 services, the record librarian may use a conversion table which shows how each disease may be reported in from the four basic services to the entire list of 21. The use of this classification will make reporting more uniform for all the hospitals and therefore make the total picture more accurate.

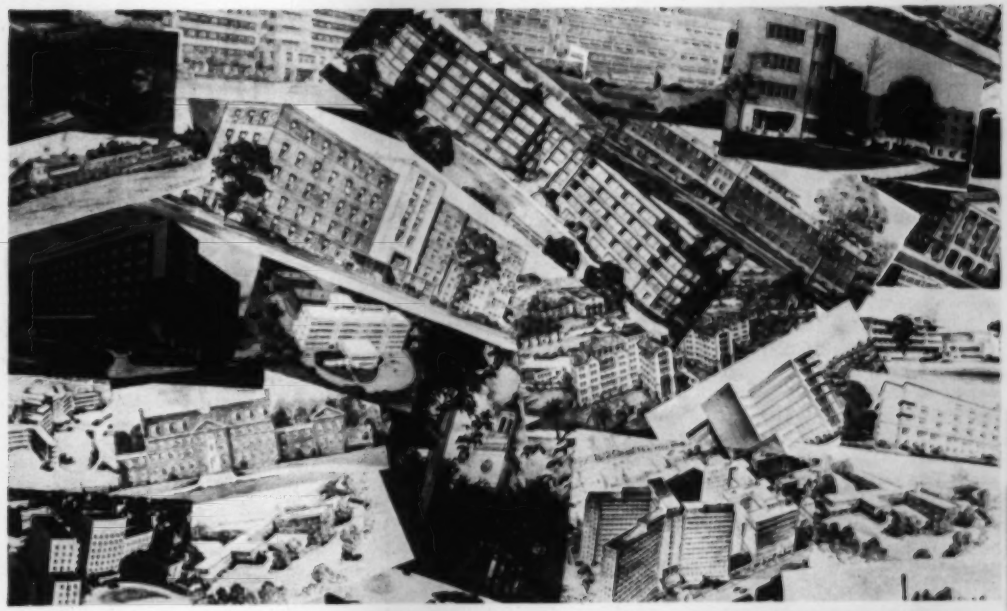
The textbook and guide is exactly what its name implies and it will fulfill that function for the medical record librarian who is using the standard nomenclature in the medical record library. It is invaluable to both the experienced and the inexperienced librarian and will become a standard reference source in the library.

Staff appointment

HOSPITAL STAFF APPOINTMENT OF PHYSICIANS IN NEW YORK CITY. Hospital Council of Greater New York. New York City, MacMillan Company. 1951. 151 p. $3.25.

A difficult study has been completed recently by the Hospital Council of Greater New York. The purpose was to discover the extent to which physicians in New York City have opportunity to be associated with local hospitals, take care of their private patients in the hospitals, and serve in the wards and outpatient departments.

The recommendations contained in the study are sufficiently general to be applicable to any hospital and to any community. Hospital boards and medical staffs who are considering the integration of general practitioners into the hospital staff



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St. Clare's Hospital (2)	Schenectady, N.Y.	2,700,000
Jefferson Medical Coll. & Hosp. (2)	Philadelphia, Pa.	2,224,000
(College—$1,524,000; Hospital—$700,000)		
St. Joseph's Hospital	Phoenix, Ariz.	2,000,000
Grace Hospital	Detroit, Mich.	2,000,000
(Share of Assoc. Bldgs. Campaign, total—$5,210,000)		
Pennsylvania Hospital (2)	Philadelphia, Pa.	1,868,000
Doctors' Hospital	New York, N.Y.	1,600,000
Post Graduate Hospital	New York, N.Y.	1,600,000
Children's Hospital (2)	Philadelphia, Pa.	1,572,996
Easton Hospital (2)	Easton, Pa.	1,411,455
United Hospitals	Rochester, N.Y.	1,095,000
(Highland, General and Homeopathic Hospitals)		
Allentown Hospital (2)	Allentown, Pa.	1,314,000
American Hospital of Paris (4)	Paris, France	1,250,200
Children's Hospital	Buffalo, N.Y.	1,250,000
Ham lton County Memorial Hosp.	Chattanooga, Tenn.	1,231,927
Provident Hospital	Chicago, Ill.	1,220,052
St. John's Hospital	Brooklyn, N.Y.	1,170,000
New Haven Hospital	New Haven, Conn.	1,100,000
St. Joseph's Infirmary	Atlanta, Georgia	1,100,000
Presbyterian Hospital	Philadelphia, Pa.	1,100,000
Hospital for Women of Maryland	Baltimore, Md.	1,019,000

(Figures in parenthesis indicate number of campaigns directed for the particular institution)

Name of Hospital	*Address*	*Amount Raised*
Flower Hospital & Medical School	New York, N.Y.	$1,025,000
Baptist Hospital	Memphis, Tenn.	1,018,000
Mercy Hospital	Springfield, Ohio	1,004,479
Brockton Hospital	Brockton, Mass.	960,000
Southside Hospital (2)	Bayshore, L.I.	946,297
Methodist Hospital	Philadelphia, Pa.	915,000
Ohio Valley Hospital	Wheeling, W. Va.	910,000
Arnot-Ogden Hospital	Elmira, N.Y.	901,024
Methodist-Episcopal Hospital	Philadelphia, Pa.	895,300
Washington Hospital (3)	Washington, Pa.	891,652
Millard Fillmore Hospital	Buffalo, N.Y.	815,945
Grace Hospital	New Haven, Conn.	814,564
Flushing Hospital	Flushing, N.Y.	801,000
St. Vincent's Hospital	New York, N.Y.	800,000
St. Peter's Hospital	Albany, N.Y.	798,000
St. John's Riverside Hospital	Yonkers, N.Y.	765,641
Greenfell Hospital & Mission	Labrador	758,216
Presbyterian Hospital (2)	Denver, Colorado	712,000
Rivethead Hospital (3)	Rivethead, L.I.	702,000
Norwood Hospital (2)	Norwood, Mass.	689,127
St. John's Hospital	Oxnard, Calif.	645,126
Silver Cross Hospital (2)	Joliet, Ill.	621,651
Memorial Hospital	Albany, N.Y.	595,000
St. Mary's Hospital (2)	Amsterdam, N.Y.	578,966
Hillcrest Hospital	Pittsfield, Mass.	570,000

(Figures in parenthesis indicate number of campaigns directed for the particular institution)

May We Add the Name of YOUR Hospital to This List?

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would do well to consider the principles expounded by the study.

It should be noted that the recommendations are subject to one basic premise: That "the extent of the hospital privileges accorded a physician should depend upon his training, experience, competence, and that his work in the institution should be subject to such supervision as may be necessary for the best interest of the patients and the hospitals who serve them."

Apart from its recommendations, the study is a presentation of facts that will have only limited application to hospitals and communities outside of New York City.

The study answers the question as to why all licensed reputable physicians should be integrated into hospitals, but does not indicate how it should be done. In this respect, it will be of limited assistance to the hospital administrator or chief of staff who now is trying to revise the hospital by-laws to create a department of general practice. — CHARLES U. LETOURNEAU, M. D.

Medical internship

THE INTERNSHIP. Roscoe L. Pullen, A.B., M.D., F.A.C.P. Springfield, Ill., Charles C. Thomas, Publishers. 1952. 35 p. $1.25.

An interesting discussion of the internship is presented by the author in an attempt to clarify the factors entering into it. The opinions expressed by the author are well presented and should be of some value to the hospital administrator who is faced with internship problems. — CHARLES U. LETOURNEAU, M. D.

Communication in industry

SPEAK UP MANAGEMENT! Robert Newcomb and Marge Sammons. New York City, Funk and Wagnalls Company, in association with Modern Industry Magazine. 1951. 308 p. $5.

Here is a valuable handbook on the art of communication within a large organization. Industrial leaders are becoming more and more aware that, for sound personnel relations and high productivity, it is necessary to keep employees informed about company policy and procedures and about changes of any kind that affect the workers.

They also recognize that the rank and file should be given channels through which they can let management know their attitudes, ideas and grievances. Beyond that, management must "communicate" with the public so that it will be informed about the aims and objectives and the extent of services of the organization. (All this is equally applicable in hospitals.)

The co-authors of this book, which is written in a forthright, readable style, get right at the heart of the subject with the statement: "The big communications job in industry, it becomes increasingly clear, is for management to persuade itself that communication is a local-level job. That means that management must do its own talking, to its own people, in its own words . . . The right sort of communication is that which is specifically tailored to answer the specific questions, locally manufactured to solve the local problems."

After a brief statement of principles on the first three pages, the book plunges into the "Ten Commandments of good communication," which are such simple rules that they might be overlooked because they seem so obvious:

1. Be sincere; you cannot make white out of black.
2. Be simple and unaffected in your language.
3. Do not overglorify the company.
4. Select competent personnel to handle your program.
5. Make your communications a top-level supervisory responsibility.
6. Do not ignore unsavory situations which your employees know exist.
7. Investigate all devices of communication and use all that will help.
8. Check constantly on the effectiveness of your communications.
9. Never let your communications program slow down.
10. Finally, see the people.

Then comes chapter after chapter of hard, factual material on how to make your communications effective. The techniques spelled out and analyzed with pertinent case histories include the following: Management newsletters, employee handbooks, annual reports, bulletin boards, employee publications, plant open houses, supervisory and employee meetings, community relations and visual and audio-visual aids.

The writers do not hesitate to chide industry on some of its failures when they say: "Employer-employee communication is the declining art of conversation at the local level . . . Talking to the working man is hard only when you have never learned or have forgotten how. If industry has become big and oppressive and subject to suspicion, it is largely because industry failed to explain itself as it went along. Even today it frequently tries to buy good will, preferring public reports of a good deed to the accomplishment of the good deed itself. Working people have commenced to be aware of this preference.

"Communication with employees means participation *on the part* of employees. That participation can be fostered and made enduring only when the employer, recognizing that communication is a local and individual thing, gives the problem of employer-employee harmony his personal, individual attention. To some, he seems to have waited a dangerously long time to make up his mind."

The book turns a critical searchlight on one of the problem areas in organization and then presents clearly and lucidly ways of meeting the problem and finding a solution for it.

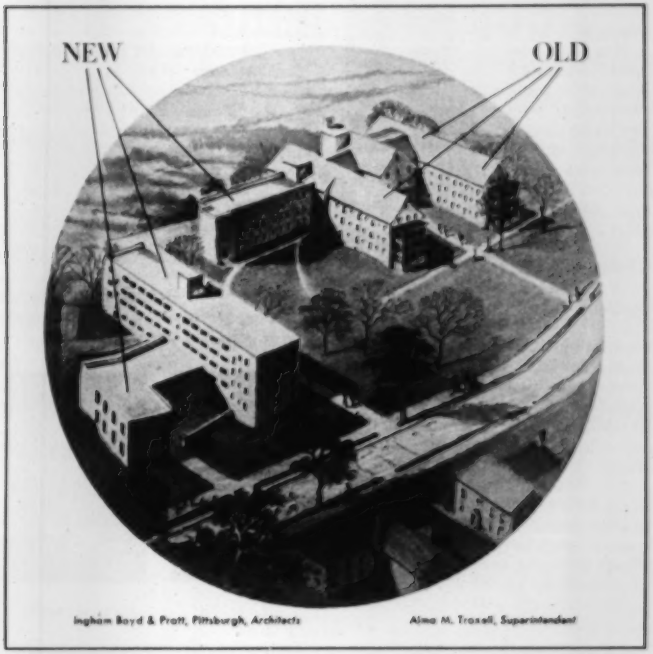
The final chapter is a list of 101 ways for management to speak up. Many of the subjects are gems of good human relations and good public relations ideas. — CORRINE OLSON.

Transcript of House action

Verbatim transcripts of the proceedings of the House of Delegates meetings on September 16, 18 and 19, 1951, are available in mimeograph form. Any member of the Association may obtain a copy without charge by writing Association headquarters, 18 E. Division Street, Chicago 10.

Oil City Hospital

raises $1,256,000 to top goal



IN the largest fund-raising campaign ever conducted in Venango County, Pennsylvania, the citizens of Oil City and vicinity contributed $1,255,808 to the Oil City Hospital Building Fund. Success in this campaign—which raised almost $113,000 more than its $1,143,000 goal—was due in large part to the careful organization of 746 volunteer workers who presented the appeal.

General Chairman Charles L. Suhr wrote concerning Ketchum direction that "You men did a splendid job," and he congratulated our staff "whose earnest efforts and devotion to duty made this possible."

Because the campaign exceeded its goal, Oil City Hospital will now be able to renovate parts of its existing structure, to erect a new wing, and to build a new School of Nursing and Nurses Residence accommodating 90 students.

This was our second over-the-goal campaign in Venango County in the past twelve months. Last year we directed the campaign for Franklin Hospital there which raised $562,000 against a $450,000 objective.

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PERSONAL *News*

JOHN N. HATFIELD, administrator of the Pennsylvania Hospital, Philadelphia, has been appointed director of Passavant Memorial Hospital, Chicago. He will begin his duties in June.

MR. HATFIELD

Mr. Hatfield will succeed RICHARD D. VANDERWAKER, who has been named director of the Memorial Center for Cancer and Allied Diseases, New York City.

A former president of the American Hospital Association, Mr. Hatfield joined the staff of Pennsylvania Hospital in 1924. He advanced from the position of purchasing agent to assistant administrator in 1927 and in 1930 was named administrator. The hospital, founded in 1751 by Benjamin Franklin and Dr. Thomas Bond, is the oldest hospital in the United States.

Mr. Hatfield attended Pennsylvania State College and later was a storekeeper in the state tuberculosis hospital in Pennsylvania. While there, he developed a system of perpetual inventory still used by Pennsylvania state institutions.

ROBERT A. MOLGREN, administrator of the Susan B. Allen Memorial Hospital in El Dorado, Kan., has been appointed administrator of the University of Kansas Medical Center, Kansas City. He succeeds the late CHARLES B. NEWELL, who died of a heart ailment in February.

Mr. Molgren is a graduate of the University of Minnesota course in hospital administration and served his administrative residency at Community Health Center and Bronson Methodist Hospital, Kalamazoo, Mich. He is a member of the American College of Hospital Administrators, the American Hospital Association, and the American Public Health Association.

J. B. FRANKLIN has been appointed administrator of the Washington County General Hospital now under construction in Greenville, Miss. The hospital is expected to open in the fall.

Mr. Franklin formerly was administrator of the Tallahassee (Fla.) Memorial Hospital. He had left that position last year with the intention of retiring.

A life member of the American Hospital Association, Mr. Franklin has also served as superintendent of the Texas Baptist Memorial Sanitarium, now Baylor University Hospital, Dallas, and as administrator of the John D. Archbold Memorial Hospital, Thomasville, Ga.

He is a fellow of the American College of Hospital Administrators.

STUART K. HUMMEL, superintendent of Silver Cross Hospital, Joliet, Ill., has been appointed administrator of Columbia Hospital, Milwaukee, Wis., to succeed JOSEPH G. NORBY, who is retiring.

MR. NORBY

MR. HUMMEL

Mr. Norby is a past president of the American Hospital Association and has been active in hospital affairs for many years. After serving as principal and superintendent of schools in various Minnesota towns, he entered the hospital field in 1923 as superintendent of Fairview Hospital, Minneapolis. He left that position in 1937 to become administrator of Columbia Hospital.

Mr. Norby is a charter member of the American College of Hospital Administrators; a past president of the Minnesota and Wisconsin hospital associations, and a member of the American Protestant Hospital Association. He also served as a member of the Board of Trustees of the American Hospital Association.

Mr. Hummel, who has served as a trustee of the American Hospital Association and on a number of Association councils and committees, will assume his new position around July 1.

He formerly was assistant superintendent of Augustana Hospital, Chicago.

Mr. Hummel is a fellow of the American College of Hospital Administrators and has also served as a member of the House of Delegates of the American Hospital Association.

JOHN H. HAYES, superintendent of Lenox Hill Hospital, New York City, and a former president of the American Hospital Association, has assumed the position of director of the hospital and will devote his time to improving the hospital facilities, planning, rebuilding, public relations, and hospital relations activities. The office of director at the hospital was created recently.

MR. HAYES

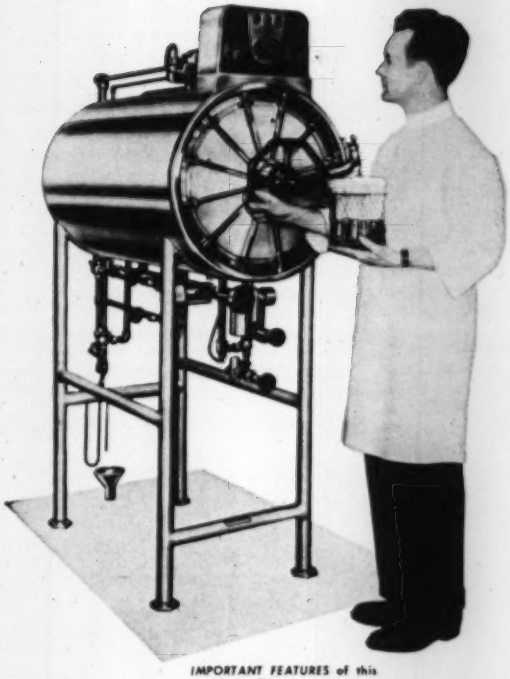
THEODORE F. CHILDS, superintendent of Brockton (Mass.) Hospital since 1945, has been appointed superintendent of Lenox Hill Hospital.

Mr. Childs entered the hospital field in 1935 as assistant purchasing agent of the New York Hospital, New York City, and later became assistant to the administrator-in-chief there. In 1942 he was appointed assistant superintendent of the Long Island College Hospital, Brooklyn, and stayed there until 1945 when he became superintendent of Brockton Hospital.

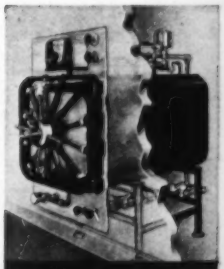
KENNETH F. WALLACE, business administrator of the University of Oklahoma Hospitals, Oklahoma City, for the past four years, has been appointed business administrator of St. John's Hospital, Tulsa.

Mr. Wallace, president of the Mid-West Hospital Association, was administrator of the Chickasha (Okla.) Hospital and Clinic from 1940 to 1948.

DR. CHARLES W. MYERS, director of Indianapolis General Hospital, and J. B. H. MARTIN, administrator of the Indiana University Medical



IMPORTANT FEATURES of this double-wall pressure steam laboratory autoclave are its all-welded Monel construction and its forged Monel end ring. Models are also available for heating by electricity or gas. Choose from two sizes: inside diameter 16", length 24", or 20x36".



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With Monel, you get other advantages, too. For Monel is not only stronger and tougher than structural steel, but it also resists corrosion and staining. It withstands heat, steam, moisture, acids, alkalis and a wide range of hospital solutions.

What's more, Monel is solid metal—corrosion-resisting all the way through. Doesn't chip, crack or craze. Has nothing to peel off or wear away. Plain soap and warm water ordinarily keep Monel bright and sanitary. But even detergents and mildly abrasive cleansers won't hurt it. Monel's good looks are permanent.

Write American Sterilizer Company, Erie, Pa., for detailed information about Monel-equipped sterilizer models. Remember, though, that Monel is on extended delivery because so much is taken for defense. By placing orders well in advance, you'll improve your chances of getting delivery of your sterilizers when you need them.

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MONEL . . . *always a wise choice for sterilizers*

Center, Indianapolis, have announced their retirement recently. Both have been active members of the Indiana Hospital Association.

Mr. Martin was president of the Indiana association in 1938 and has been chairman of the joint committee of the Indiana Hospital Association and the Indiana State Nurses' Association since 1944.

Dr. Myers was president of the Indiana Hospital Association in 1946.

W. J. FENDER, JR., former administrator of the Jay County Hospital, Portland, Ind., now is administrator of the Phoebe Putney Memorial Hospital, Albany, Ga. He served as assistant comptroller at Presbyterian Hospital, Chicago, before going to Jay County Hospital.

Mr. Fender has been succeeded at Jay County Hospital by L. L. LANDIS, formerly purchasing agent at Memorial Hospital, South Bend, Ind.

SISTER M. KATHLEEN has been appointed administrator of St. Mary's Hospital, Racine, Wis., succeeding SISTER M. ALPHONSE who now is at St. Francis Hospital, Cape Girardeau, Mo.

JAMES G. EVANS, a recent graduate of Northwestern University's course in hospital administration, has been appointed assistant administrator of Peoples Hospital, Akron, Ohio.

OSBORNE L. HARVEY, administrative assistant at New England Center Hospital, Boston, has been promoted to assistant administrator of the hospital, which is part of the New England Medical Center.

He is a member of the American Hospital Association.

HENRY AMICARELLA has been appointed assistant administrator of the Evanston (Ill.) Hospital, succeeding FREDERICK G. WHELPLY, who recently became administrator of the Wyandotte (Mich.) General Hospital.

Mr. Amicarella received his masters degree in hospital administration from Northwestern University and served his administrative residency at the Colorado General Hospital, Denver. He served as a medical administrative officer in the Army from 1943 to 1946 and as executive assistant in the Veterans Administration Hospital, Fort Lyon, Colo., from 1946 to 1949.

DANIEL E. GAY has resigned as director of the Lankenau Hospital, Philadelphia, to serve as special consultant to the board of trustees until the new building program of the hospital is completed.

Mr. Gay has been director of the Lankenau Hospital for four years and initiated the building program for the new $8,000,000 Lankenau Hospital.

RAYMOND F. HOSFORD, formerly superintendent of the Bradford (Pa.) Hospital, has been appointed director of the Lankenau Hospital.

Before entering the hospital field, he was purchasing agent for industrial companies in Pennsylvania. He became superintendent of Bradford Hospital in 1932.

Mr. Hosford is a member of the American Hospital Association and a past president of the Hospital Association of Pennsylvania.

Before coming to Philadelphia, Mr. Gay was administrator of the Phoenixville (Pa.) Hospital. He is a member of the American College of Hospital Administrators, the American Hospital Association, and of the advisory board of the Hospital Council of Philadelphia. He is president of the Philadelphia Hospital Association and chairman of the Council on Hospital Association Development of the Hospital Association of Pennsylvania.

MARVIN W. HINSON, formerly administrator of the Good Samaritan Hospital, Charlotte, N. C., has been appointed to the Washington office of the United Mine Workers of America Welfare and Retirement Fund.

Mr. Hinson will develop liaison with the various hospitals that serve the beneficiaries of the U. M. W. Welfare and Retirement Fund.

JOHN K. LOCKHART, a recent graduate of the Duke Hospital administrative training program, now is administrator of the Roanoke-Chowan Hospital, Ahoskie, N. C. He succeeds ROBERT GANTT, who now is administrator of the Stanly County Memorial Hospital, Albemarle, N. C.

RHEA C. ACKERMAN has been appointed assistant administrator of the Morton Hospital, Taunton, Mass.

Miss Ackerman formerly was assistant administrator of Children's Hospital, Los Angeles.

WINSTON WHITFIELD has resigned as administrator of Kings Daughters Hospital, Yazoo City, Miss., to assist his father, B. T. WHITFIELD, in the management of the Corinth (Miss.) Hospital. He has been succeeded by JACK B. MCCORD, formerly office manager of the Methodist Hospital, Memphis, Tenn.

H. H. BOYD has been appointed administrator of Leake County Memorial Hospital, Carthage, Miss. He succeeds J. C. TAYLOR, who resigned to work with the state health department.

THOMAS J. FINN has been appointed superintendent of the B. S. Pollak Hospital for Chest Diseases, Jersey City, N. J.

For 13 years he has been with the New Jersey Civil Service Department and for the past six years he has been concerned with job classification and valuation in local government.

He has conducted various surveys of organization structures in public hospitals and institutions in New Jersey.

DR. BENJAMIN P. POTTER is medical director of the hospital.

MRS. RUTH GOOCHEE, R.N., has resigned as superintendent of the Port Allegany (Pa.) Community

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INSTITUTES

(Continued from page 6)

Institute on Purchasing, in conjunction with Middle Atlantic Hospital Assembly—May 19-20; Atlantic City (Chalfonte-Haddon Hall).

Institute on Engineering—June 2-6; Chicago (Knickerbocker Hotel).

Institute for Medical Record Library Personnel—June 9-14; Tulsa (University of Tulsa).

Institute on Pharmacy—June 23-27; Toronto (University of Toronto).

Institute on Laundry—October 13-17; Detroit (Sheraton Hotel).

Institute on Nursing Service—October 20-24; Berkeley Calif. (Claremont Hotel).

Institute on Purchasing—November 10-14 St. Louis (Sheraton Hotel).

Institute on Accounting—November 10-14; Chicago (Knickerbocker Hotel).

Institute on Housekeeping—December 1-5; New Orleans (St. Charles Hotel).

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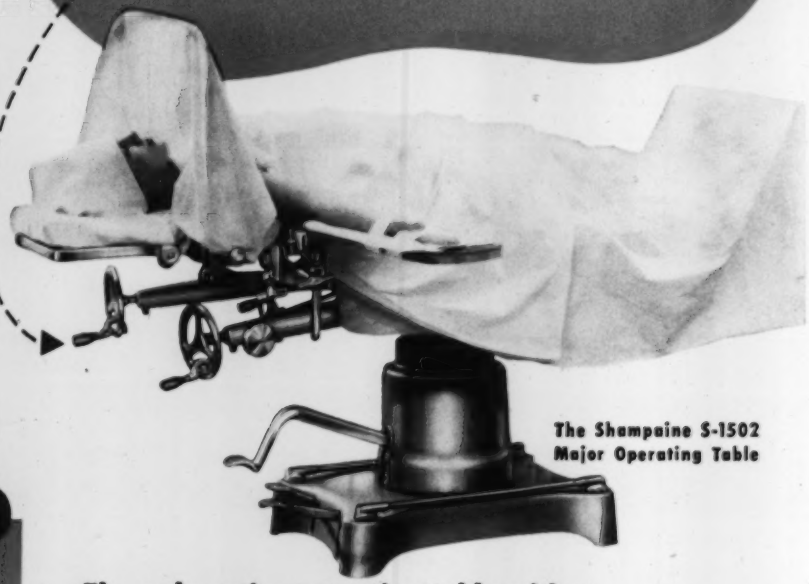

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Hospital after four and one-half years in the position. She is a graduate of Bradford (Pa.) Hospital School of Nursing.

JOHN B. MALLON has been promoted to superintendent of the Suburban General Hospital, Pittsburgh. He formerly was assistant superintendent of the hospital.

Mr. Mallon succeeds MRS. LUCETTA K. ROSE, who resigned because of ill health.

Correction

In the March issue of HOSPITALS, it was erroneously stated that M. EVELYN MILLIS, R.N., has succeeded KENNETH E. BROOKS as administrator of the Hayswood Hospital, Maysville, Ky. The editors regret this erroneous report.

Deaths

CHARLES B. NEWELL, administrator and business manager of the University of Kansas Medical Center, Kansas City, for the past seven years, died February 15.

Mr. Newell was a past president of the Kansas Hospital Association and of the Mid-West Hospital Association. He served as vice president of the Kansas City Area Hospital Council in 1948 and was a member of the American Hospital Association's Committee on Revision of Medical Record Forms. At the time of his death he was a nominee of the American College of Hospital Administrators.

An educational trust fund is being established for Mr. Newell's three children as a living memorial to him. Trustees of the fund are DR. LEE H. LEGER, BLAKE WILLIAMSON, and BRUCE W. DICKSON, all of whom were close associates of Mr. Newell.

DR. FRANCIS E. O'BRIEN, retired superintendent of the Hampshire County Sanatorium in Northampton, Mass., died February 15. He had headed the sanatorium for 30 years before his retirement February 1.

DR. HERBERT G. MCMAHAN, an Indiana psychiatrist, died March 4 in a fire in his hotel room in Topeka, Kan.

Dr. McMahan, a graduate of Indiana University, became medical superintendent of the new Norman M. Beatty Memorial Hospital in Westville, Ind., last December. Before that he was a psychiatrist in the Illinois State Hospital at Manteno.

HELEN J. LEADER, director of nurses at the Presbyterian Hospital in Philadelphia since 1936, died February 27 of a cerebral hemorrhage.

She had served as director of nursing at the Truesdale Hospital, Fall River, Mass.; director of nurses at Christ Hospital, Cincinnati, and, during World War I, as assistant director of nurses at Episcopal Base Hospital No. 34.

SISTER CHARLOTTE BOEKHAUS, who helped organize the Deaconess Hospital, Lincoln, Ill., and later was director of nurses and administrator there, died in St. Louis March 3. She was an honorary member of the American Hospital Association.

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Use of Personnel to be Studied

Because of a serious shortage of nursing service in the United States, the Health Resources Advisory Committee of the Office of Defense Mobilization has announced the appointment of a special subcommittee to study how to make the best possible use of the available number of hospital workers.

The new group will analyze and coordinate for distribution all information possible on how hospital services can be kept functioning at the highest possible level of effectiveness during the mobilization period.

Two members of the Health Resources Advisory Committee will be ex-officio members of the new subcommittee. They are Dr. Edwin L. Crosby, director of Johns Hopkins Hospital, Baltimore, and president-elect of the American Hospital Association, and Mrs. Ruth Kuehn, dean of the University of Pittsburgh School of Nursing.

The appointment of the subcommittee was announced by Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee and associate editor of the New York *Times*.

Social Security Aided 4,000,000 in 1951

Four million aged, widows and orphans were receiving benefits under the old age and survivors insurance program in 1951, Federal Security Administrator Oscar R. Ewing revealed in his annual report.

This marked an increase of 1,500,000 people during the year and was due largely to the expansion of social security as a result of amendments passed in 1950.

Mr. Ewing pointed out that congressional action in 1950 marked "one of the greatest advances in social legislation since the origin of the Social Security Act 15 years ago," in that more than 10,000,000 workers became eligible for old age and survivors insurance. At the same time, the size of monthly payments were doubled for those receiving low benefits and increased 50 per cent for those receiving maximum benefits.

The increase in the number of social security beneficiaries reduced the number of aged and dependent children on public assistance rolls and, therefore, lightened the burden on the federal and state governments and private charities, Mr. Ewing added.

VA Committee Recommends Pharmacy Training Program

A two-year pharmacy residency and academic training program for Veterans Administration hospitals has been recommended by the Veterans Administration Special Pharmacy Training Committee.

The program will depend on formal approval by the Veterans Administration and on development of administration procedures and operational details.

Under the proposal, recent pharmacy graduates holding bachelor of science degrees and registered in one of the states would be selected for training in Veterans Administration hospitals and enrolled in affiliated colleges or universities for graduate study in pharmacy. The study would be taken at the same time as on-the-job training in hospital pharmacy.

The committee recommended that accredited schools and colleges of pharmacy be invited to participate in the program if they offer graduate study in pharmacy and are located near adequately staffed and equipped Veterans Administration hospitals.

Armed Forces Will Induct 510 Dentists Before June

The Department of Defense has announced that 335 dentists will be inducted into the armed forces this month, and 175 will be called in May.

Of the total requested, 145 will be assigned to the Army, 290 to the Navy, and 75 to the Air Force.

The dentists are Priority I registrants who were students in the Army Specialized Training Program or similar programs administered by the Navy, or who were deferred from service during World War II to attend dental school and who have served less than 90 days in the Armed Forces, the Coast Guard or the United States Health Service after completion or release from the courses of instruction.

The dentists were called for induction, said the Department of Defense, because the number of Priority I dentists volunteering for commissions is not expected to meet requirements for replacements of dentists who will complete terms of military service.

Dr. Mider Designated Scientific Director

Dr. G. Burroughs Mider, Rochester, N. Y., has been appointed scientific director of the National Cancer Institute, National Institutes of Health, Bethesda, Md.

Dr. Mider is professor of cancer research and coordinator of cancer teaching in the School of Medicine and Dentistry at the University of Rochester.

When the National Cancer Institute building was completed in 1939, Dr. Mider was transferred there to become a member of the research staff. In 1941 he became instructor in pathology at the Medical College of Cornell University, and the next year was made assistant professor. In 1944 he joined the faculty of the Medical Department of the University of Virginia as associate professor of pathology. He has been on the faculty of the School of Medicine and Dentistry at the University of Rochester since 1945.

Dr. Mider is a diplomate of the American Board of Pathology, and a member of the American Association of Pathologists and Bacteriologists, the American Society for Experimental Pathology, and the American Association for Cancer Research. He also is a member of the board of directors of the New York State Division of the American Cancer Society, and a consultant to the Rochester Laboratories of the Atomic Energy Commission.

Research Chief Appointed

The appointment of Dr. John C. Nunemaker to the position of chief of the research division, Research

—U. S. Air Force Photo

and Education Service, Department of Medicine and Surgery in Washington, D. C., has been announced by Rear Adm. Joel T. Boone, chief medical director of the Veterans Administration.

Dr. Nunemaker formerly was chief of medical service at the Veterans Administration Hospital in Salt Lake City and assistant professor of medicine at the University of Utah in the College of Medicine.

Dr. Nunemaker is a diplomate of the American Board of Internal Medicine and a member of the American Rheumatism Association. He began working for the Veterans Administration in 1946 after serving for four years as an officer in the Army. During his Army service, he was commanding officer of the 56th Station Hospital, then situated in Cairo, Egypt, and later was surgeon of the Middle East Service Command.

Consolation Gets Flight Deck

A "flight" deck for helicopters has been built on the U. S. Navy Hospital Ship Consolation for around-the-clock ambulance service between the battle line and the hospital ship. The innovation was tested successfully by the Navy for six weeks in Korean waters.

As a result, the Navy soon will install helicopter flight decks on the remaining hospital ships and on many other naval vessels.

The Consolation carried out the experiment from December 18 to January 24, during which time 23 landings were made on the ship by Marine, Army and Air Force helicopters delivering more than 400 patients.

Capt. John W. McElroy, commanding officer of the floating hospital, said recommendations forwarded to Washington provided for two helicopters to be assigned to each hospital ship. Under the plan, these hospital ship helicopters would be painted white with red crosses. They would be called flying ambulances and be entitled to all the privileges of any other ambulance since they would be doing only hospital work.

1952-53 Medical Residencies

In selecting special registrants and reserve officers for medical residencies for the hospital year 1952-53, the National Advisory Committee to the Selective Service System recommends that preferance should be given to applicants in the following order:

1. Priority IV—With the exception of those having double liability.

2. Priority III.

3. Priority II—In the order of their months of service. This means that preference should be given to those who have had 18 to 21 months of service, then 15 to 18 months, and so forth, with the understanding that some Priority II officers and registrants may be called before July 1, 1953.

4. Priority I—None, except under very exceptional circumstances, and probably in no instance except where there is a question of servicing an isolated community hospital.

Physician Induction Delayed

The induction of 485 Priority I physicians, originally scheduled for August and September 1951, has been further postponed until May of this year, the Department of Defense has announced.

The delay in induction is possible, said the department, because there are enough Priority I reserve officers to meet military requirements for individual calls to active service. The primary source of these officers has been Priority I registrants who accepted reserve commissions. If the number of registrants who accept reserve commissions should fall below the number required, the shortage will be made up through induction, reports the department.

Hydrazine Deliveries Deferred

The Army Ordnance Department announced on March 12 it is voluntarily deferring deliveries of hydrazine, an experimental compound in rocket propulsion investigations, so that there may be minimum interference with production of the chemical for further clinical studies in tuberculosis.

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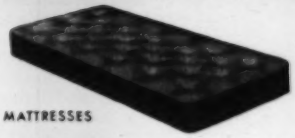

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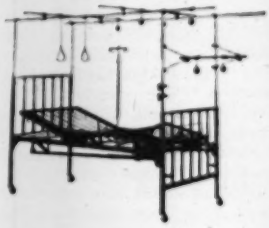

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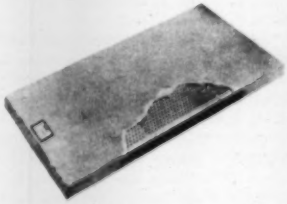

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Senate Hears Testimony on Health Bills

In Washington—both on and off Capitol Hill—March was a month distinguished by the quantity of public hearings and investigations on subjects of direct interest to the nation's hospitals.

The pros and cons of establishing a Department of Health . . . whether federal controls on selling of barbiturates should be tightened . . . feasibility of Congress enacting an EMIC program, by which the treasury would pay obstetrical, infant care and general hospital bills of servicemen's dependents . . . advantages and disadvantages of both federal and private support of medical, dental and nursing schools . . . size of sums Washington should appropriate for aid to medical research in hospitals, schools and laboratories . . . war damage liability of federal government, where hospitals are concerned—these were the principal issues debated in the Capital last month.

By and large, the great volume of testimony presented was "for the record," rather than a definite harbinger of new legislation. Among the items listed above, the only one that is certain to be translated into law is that dealing with appropriations for the Public Health Service, whose National Institutes of Health allocate research grants. Nevertheless, this flurry of activity demonstrates that Congress is focusing much attention on national health affairs.

A noteworthy side development was the issuance of a report by the Public Health Service's Division of Hospital Facilities purporting to show that the country's existing 1,010,000 acceptable hospital beds (exclusive of 190,000 federal beds) comprise only about 50 per cent of the real need. Provision of 874,000 more is deemed necessary—232,000 general beds, 329,000 in mental institutions, 55,000 for the tubercular and 258,000 for chronic cases.

Humphrey, Lehman Bills: A full week of public hearings—conducted by the Senate subcommittee on health legislation—on hospitalization and medical care benefits for dependents of enlisted men failed to produce the wave of enthusiastic support that Congressional sponsors had anticipated. The bills at issue were S.1245 and S.2337, introduced by Senators Hubert H. Humphrey and Herbert Lehman, respectively. The former is limited to maternity and infant care, corresponding to the EMIC program of World War II. The Lehman bill provides for the same plan, and in addition would make *all* dependents of enlisted men eligible for inpatient hospitalization benefits. Under both plans, the full expense would be borne by the federal government.

Dr. Crosby Testifies: Testifying as president-elect of the American Hospital Association, Dr. Edwin L. Crosby opposed both bills in their present form as leaning toward "too much paternalistic interference on the part of the federal government." The soundest alternative, he declared, would be to have Uncle Sam follow the lead of American industry and provide health insurance coverage for these dependents on a contributory basis. Blue Cross and Blue Shield plans would serve as intermediaries. Each serviceman could decide whether or not he wished to participate.

Dr. Crosby summarized as follows:

"Let the federal government encourage men in military service to authorize the deduction of monthly premiums from their service pay, to be transmitted by the federal government to voluntary health insurance plans that will assure broad protection against ordinary illnesses and disabilities and with service available from any hospital or any doctor in any community in the nation. Let the federal government, if it feels that additional federal funds are due this group of citizens, offer to pay part of the cost of voluntary health insurance just as many employers participate in such programs today. Let this program be completely voluntary for each serviceman, with the further protection that he may continue such insurance in effect for himself and his dependents after his discharge from service."

A.M.A. Viewpoint: Spokesmen for the American Medical Association, Dr. Edwin S. Hamilton and Dr. Woodruff L. Crawford, expressed opposition to the bills on grounds that need has not been demonstrated. A similar position was taken by Dr. L. E. Burney, representing the Association of State and Territorial Health Officers, though he emphasized that if a program is launched its members will give it their wholehearted cooperation. The same view was presented by Dr. Philip S. Barba, a Philadelphia pediatrician, testifying as an individual.

Favorable Testimony: Witnesses who spoke more favorably of the Humphrey and Lehman bills included representatives of the Department of Defense, the Army Surgeon General's Office, the Children's Bureau, the American Public Health Association, the American Legion, labor organizations and social service groups.

Also, Rep. Reva Beck Bosone (D., Utah), gave favorable testimony, although she indicated that the alternative proposed by Dr. Crosby, namely, voluntary participation in Blue Cross and Blue Shield plans, might well prove to be the wisest course.

Even among this group, however, few witnesses had anything to say about the controversial Title 2 of the Lehman bill—federal payment of hospital bills incurred by servicemen's dependents. Their reticence was attributed largely to the fact that it is virtually impossible to estimate what this scheme would cost the government annually, whereas statistics are available to forecast the cost of an EMIC-type program limited to medical and hospital expenses of obstetrical and pediatric care.

Health Department Opposed by National Groups

The Senate Expenditures Committee concluded public hearings late in March on the proposed Department of Health, with presentation of strong opposition testimony by the American Legion and the Veterans of Foreign Wars. Their objections were directed chiefly at the bill's (S.1140) provision that all veterans' hospitals shall be placed under the central agency.

Earlier in the month, opposition arguments were presented by Federal Security Administrator Oscar R. Ewing and the American Medi-

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cal Association—strangely united on this particular issue—and by the Department of Defense. Supporting testimony came solely from a group of physicians representing the National Doctors Committee for Improved Federal Medical Services. This group is an affiliate of the Citizens Committee for the Hoover Report.

Dr. Leroy W. Hull, chief of department of urology at Grace Hospital in Detroit, charged that coordination and planning are lacking in the federal hospital system. One result, he said, is that Washington appropriates millions to support construction of nongovernment hospitals and then various federal agencies compete with one another in personnel "raids" on these institutions.

Dr. Samuel Arthur Garlan, a New York cardiologist on the staff of Lenox Hill Hospital, said: "The emphasis on curative medicine and the uncontrolled building of hospitals is causing a maldistribution of doctors and stockpiling of doctors in unnecessary institutions to the detriment of large areas of the population."

Dr. Lawrence A. Pratt, a chest surgeon on staffs of Detroit's Grace and Memorial hospitals, warned that "we cannot afford to delay either the coordination of federal medical programs or definite plans to integrate our federal hospitals with other tax-supported and private institutions in the event of outbreak of war."

Dr. Harry F. Klinefelter Jr., a Baltimore internist on staffs of Johns Hopkins, Union Memorial and Women's hospitals, told the investigating committee: "Many private hospitals are unable to compete with the federal agencies for competent personnel, simply because the government can make more attractive financial offers. At the same time, the ever expanding federal program is taking away some of the patients who otherwise would be cared for in private hospitals."

Capital observers are strongly of the opinion that the Senate committee will pigeonhole the Department of Health bill and urge enactment, instead, of a bill that would establish by law a Federal Board of Hospitalization to coordinate construction and administration of government hospitals. It would work in close relationship with the country's private hospitals, particularly those erected under the Hill-Burton program.

House Committee Studies Barbiturate Controls

The House Ways and Means Committee now is studying barbiturate controls. Public hearings have been held and, while tighter restrictions may be recommended, chances are regarded as slim for passage of anything as drastic as the Rogers Bill, which would place barbiturates on par with morphine and other narcotics in the matter of federal regulation.

War Damage Payments

A pending legislative matter of importance to hospitals is a bill (S.1848) on war damage payments to hospitals and other institutions in event of enemy attack. Appearing in behalf of the Blue Cross Commission, E. A. van Steenwyk, Philadelphia, and Benjamin Long, Detroit, advised the Senate Banking and Currency Committee that if such a law is placed on the statute books it should have safeguards against federal control.

Federal Support of Research

A series of public hearings on federal appropriations for support of medical research were conducted by the Senate Appropriations Committee in March. Increased funds for grants-in-aid to hospitals and medical schools to support clinical and laboratory investigations of cancer, heart disease, mental illness, neurological diseases, arthritis and blindness were recommended by a large battery of physicians. They included Dr. Louis Katz, Michael Reese Hospital; Dr. Paul D. White, Boston; Dr. Joseph Bunim, Bellevue Hospital; Dr. Dan Gordon, Cornell Medical School; Dr. C. P. Rhoads, Memorial Cancer Center, and numerous others.

Support of Schools: Financial support of schools of medicine, dentistry, nursing and public health was the subject of a round table discussion conducted March 11 under auspices of the President's Commission on Health Needs of the Nation. Participating as representatives of nursing profession were Veronica Lyons, associate dean, New York Hospital-Cornell University School of Nursing, and Mary Brackett, Hartford (Conn.) Hospital.

Nursing Subsidy Bill

After months of delay, signs are growing that House Interstate and Foreign Commerce Committee plans to take action soon on a bill (H.R. 910) authorizing federal subsidies to schools of nursing. It was introduced in January, 1951, by Rep. Frances Bolton (R., Ohio) and hearings were conducted later in the same year. The committee held three executive sessions on H.R. 910 in mid-March and a favorable report on the measure—though possibly with some amendments—is far from improbable.

Ownership of Oil Tidelands

Another interesting bill awaiting Congressional action is one sponsored by Rep. John F. Kennedy (D., Mass.). Its introduction was an outgrowth of current dispute over ownership of oil-rich tidelands of Texas, Louisiana and California. The Kennedy Bill (H.J. Res. 381) proposes that oil royalties from these tidelands be placed in a special Treasury fund and disbursed for national health projects —specifically, assistance to hospitals, professional schools and students in training for medicine, nursing and health sciences.

Clinical Research in Cancer

Two grants for care and clinical research in cancer have been received by the George Washington University from the Alexander and Margaret Stewart Fund.

The grants are designed to help and comfort persons who have incurable cancer. The fund has awarded $25,000 for home care of patients too ill to come to the clinic for treatment but not ill enough to require hospital care. An additional $20,184 has been given for research to evaluate methods of treating cancer patients who are beyond help by routine surgical or x-ray therapy.

3,800,000 Live Births Recorded in 1951

Live births in the United States during 1951 amounted to more than 3,800,000 for the second time in history and topped the 1950 birth total by more than 200,000, according to vital statistics released by the Public Health Service.

The 1951 total may be an all-time high for the United States, the report said.

The number of children born in 1951 was estimated at 3,833,000 as compared with 3,818,000 born in 1947, the previous record year. The annual birth rate for 1951, based on registered births alone, rose to 24.5 per 1,000 population, an increase of 4.3 per cent over 1950.

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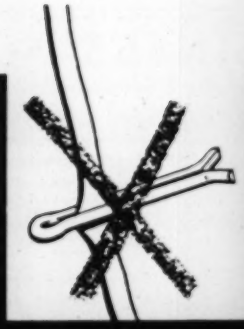

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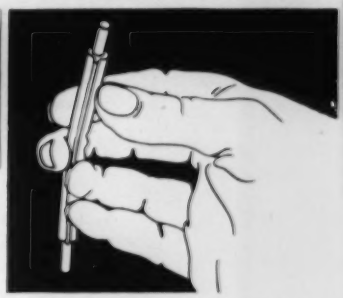
With the same hand—continue to bend clamp into closed position.



With the same hand—adjust rate of flow by bending clamp to desired angle...as many times as you want without loss of precision.

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Convention Program Being Developed

Preliminary program plans for the 54th annual convention of the American Hospital Association September 15-18 in Philadelphia are now being developed by the Association's convention program planning committee.

As in previous years, general sessions, business meetings, discussions and evening social events will make up the major part of the program. This year's convention, however, will be distinguished by its national figures and by the timeliness of topics to be discussed.

At the first general session Monday afternoon, convention program planners have kept in mind that 1952 is a national election year, and are arranging a program on the political scene as it concerns hospitals.

General sessions also are being planned for Tuesday and Wednesday mornings and afternoons. Special sectional sessions will be held Thursday morning and afternoon, at which problems of hospitals will be presented.

As before, the convention will be officially in session at the opening of the exhibits Monday morning.

At an informal session Tuesday evening, finalists in the "Stretching Your Hospital Dollar" contest will present their ideas, and the winners will be selected by the audience.

The Association's House of Delegates will meet Sunday morning and afternoon and Wednesday evening to conduct annual business.

A special event Monday evening will be a cruise on the Delaware River aboard the "Delaware Belle." A buffet supper will be served aboard the boat, with dancing and a floor show afterwards.

The annual banquet and presentation of awards is scheduled for Thursday evening as the closing program of the convention. At that time, President-elect Edwin L. Crosby, M.D., will be installed as president, succeeding Dr. Anthony J. J. Rourke.

Also scheduled on this year's program are the Federal Hospital Luncheon Tuesday; the Catholic sisters' luncheon Wednesday; the past presidents' dinner Tuesday evening, and the women's auxiliary luncheon Thursday.

Convening with the American Hospital Association at Philadelphia will be the American College of Hospital Administrators, the Women's Hospital Auxiliaries, the American Association of Nurse Anesthetists, the state planning directors and the consultants.

Members of the Association's Committee on Convention Program Planning are: *Chairman*, Dr. Rourke, Stanford University Hospitals, San Francisco; Ray E. Brown, University of Chicago Clinics; Dr. Crosby, The Johns

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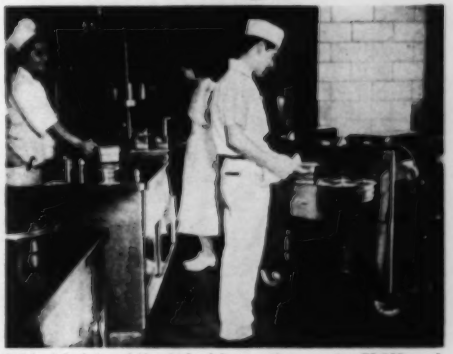
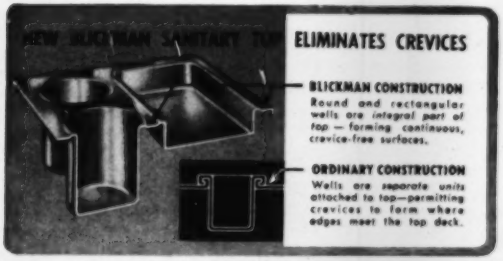
• With its numerous top-deck arrangements, the new Blickman-Built *All-Purpose* Food Conveyor is specially designed to take care of your different food service requirements. For ward service, you store the limited variety of foods in a few of the larger insets. To accommodate the more diversified foods in your selective menus and special diets, simply take out the large insets and substitute a number of smaller containers. Eighteen square and rectangular insets are provided with the conveyor in six different sizes. These can be arranged in various combinations. Two heated drawers and lower compartments add to the ample storage space provided in the top deck.

You obtain these additional advantages: Food is kept piping-hot; arrives on time, in kitchen-fresh, palatable condition — important factors in diet-therapy. You save time and labor, waste less food. Since food is transported in bulk, fewer trips are required, dish and tray trucks are eliminated. Cleaning, too, is a swift and easy task. Blickman-Built stainless steel food conveyors are the only standard models available with one-piece, crevice-free body and seamless top-deck construction. These, and other important aids to mass-feeding efficiency are yours—when you use Blickman-Built *All Purpose* Food Conveyors — the finest made.



367-bed Beth Israel Hospital, of Boston, Mass., serving 70,000 meals per month, of which 30,000 are patient meals, has found an effective solution to their mass-feeding problem in the Blickman-Built *All-Purpose* Food Conveyor. Illustration shows truck being loaded in main kitchen. Conveyors distribute hot foods to serving pantries on each floor.

At Stamford (Conn.) Hospital, conveyor carries bulk food from central kitchen to serving kitchens on each floor. Shown here is nurse carrying loaded tray from serving kitchen after it has been loaded on *All-Purpose* Food Conveyor. Patient gets the food hot and appetizing.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You are welcome to our exhibit at the Southeastern Hospital Conference, Biltmore Hotel, Atlanta, Ga., April 16-18.

Hopkins Hospital, Baltimore; Dr. Jack Masur, assistant surgeon general, Public Health Service, Washington, D. C.; Dr. Albert W. Snoke, Grace-New Haven Hospital, New Haven, Conn; Dr. Charles F. Wilinsky, Beth Israel Hospital, Boston, and Ronald Yaw, Blodgett Memorial Hospital, Grand Rapids, Mich.

1952 Convention Exhibit To Set New Record

More than 370 companies have requested about 650 booths for commercial exhibits at the 1952 convention of the American Hospital Association in Philadelphia September 15-18. These applications account for virtually all the available space in the exhibit hall.

This year's exhibit of hospital equipment and supplies will be the largest in the history of the Association. Last year a total of 336 companies occupied 580 booths. The entire exhibit, as well as meeting halls, restaurant and registration booths, will be on one floor in Philadelphia's Commercial Museum and Convention Hall, and delegates will pass through the exhibit on their way to and from general program sessions.

The city of Philadelphia is building a permanent meeting hall adjacent to the museum. The Association probably will be the first group to use the new meeting rooms.

Admission to the exhibit hall this year, as last, will be by badge only. Badges are given free to eligible registrants, including persons employed by or affiliated with hospitals or institutional health services, and to bona fide employees of exhibiting companies. They also are available to representatives of nonexhibiting firms on the last half day of the show. The exhibit at no time will be open to the general public.

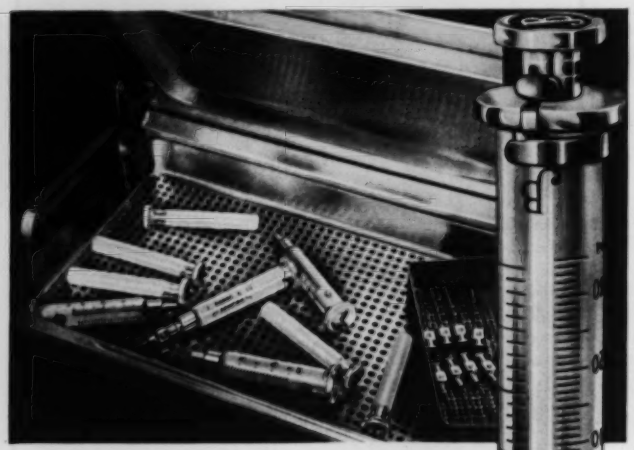
The annual exhibit of the Association this year will occupy a space in the center of the exhibit hall. As in previous years, Association bulletins, pamphlets and publications will be on display and free material will be available. Members of the headquarters staff of the Association will be on hand each day to answer questions, distribute literature and explain services displayed. The exhibit will be a convenient meeting place for members, as well as a place to learn about services of the national association.

Finance Commission Appoints Special Advisory Group

Eight experts in technical and administrative aspects of hospital care financing have been appointed to the new technical advisory committee of the Commission on Financing of Hospital Care, Chicago.

The committee will advise the commission in the selection and development of its research projects.

Included on the committee are: Ray E. Brown, superintendent, University of Chicago Clinics; Helen L. Bunge, dean, Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland; Andrew T. Court, Ph.D., economist, General Motors Corporation, Detroit; Dr. James P. Dixon, commissioner of health, city of Philadelphia; Dr. H. B. Mulholland, professor of medicine, School of Medicine, University of Virginia, Charlottesville; George St. J. Perrott, Ph.D., chief of the Division of Public Health Methods, Public Health Service, Washington,



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Hospital administrators, physicians and nurses will like these additional new features, too—the indestructible ceramic markings, the strong permanent metal tip, and the corrosion-resistant glass. All these improvements will save you time, temper and trouble. Ask your regular supplier for details.

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* Seated: Howard R. Lichtwahl, Bernard H. Lawson, Cecil P. Dodge, Herbert G. Carhart, Jr., John C. Marcellus, Warren E. Tucker, Harry F. Campbell, Robert S. Niewenhous.

Standing: Daniel F. Mulvey, Robert B. Snook, James H. Fraser, Frank E. Slattery, Edwin E. Staudt, Brendan Sullivan, Robert M. Applewhite, Herbert Schultz, William Morgan Welsh, Reynolds Johnson, Ernest S. Vena.

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D. C.; C. Rufus Rorem, Ph.D., executive director, Hospital Council of Philadelphia, and E. A. van Steenwyk, executive director, Associated Hospital Service of Philadelphia.

The new advisory committee held its first meeting March 21-22 in Philadelphia and reviewed findings of the regional conferences sponsored recently by the commission to determine the urgent day-to-day problems that are crippling efforts to finance high quality hospital care for all persons. The committee also formulated recommendations for study projects to be undertaken by the commission, which will act on them at its meeting April 19 in Washington, D. C.

Graham L. Davis, director of the commission, said it planned to appoint other special advisory committees and panels of consultants as specific research projects are developed.

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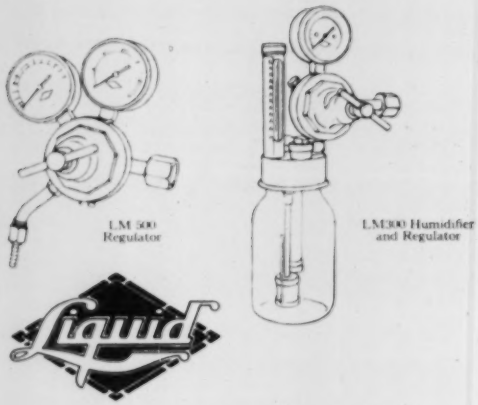

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New Research in Markets

Donald F. Scalzo, formerly assistant administrator at Evangelical Hospital, Chicago, and administrative resident at Grant Hospital, Chicago, has joined the staff of HOSPITALS, journal of the American Hospital Association. Mr. Scalzo will head a new section on hospital market research.

Mr. Scalzo is a graduate of Loyola University and received his masters degree in hospital administration from Northwestern University in 1951.

In his new position with HOSPITALS, Mr. Scalzo will expand the magazine's program of interpreting hospital problems and requirements to industries in the field.

Auxiliaries Join Association

Ten additional women's hospital auxiliaries recently became institutional members (Type V) of the American Hospital Association. They are:

Blessed Martin de Porres Hospital Women's Auxiliary, Mobile, Ala.
Women's Auxiliary of St. Mary's Hospital Clinic, San Francisco.
Women's Auxiliary of the Graham Hospital, Canton, Ill.
Ladies Board of Marlborough (Mass.) Hospital.
Mother Seton Auxiliary, St. Joseph Hospital, Mount Clemens, Mich.
Georgetown (S.C.) County Memorial Hospital Auxiliary.
Lubbock (Texas) Memorial Hospital Women's Auxiliary.
Women's Auxiliary of the Tomah (Wis.) Memorial Hospital.
Women's Auxiliary of Anderson Orthopedic Hospital, Arlington, Va.
University of Virginia Hospital Circle, Charlottesville, Va.

Human Relations Commission Outlines Study Program

The new Commission on Human Relations met recently to discuss methods of research, to develop criteria for selecting hospitals to be included in the study, and to outline the purposes of its study of hospital human relations.

Dr. Temple Burling of Cornell University defined human relations for purposes of the research as "the relations of employees in social situations, particularly in the hospital." Dr. Burling is study director of the commission.

The relations of employees include those to the organization, to the job, to techniques, individual to individual, individual to group, and groups to groups. The study

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group is planning to concentrate its attention on the personality, family background and motivation that employees bring to particular jobs in the hospital; what effect job operations have on the employee and the group; what effect personnel policies, or lack of them, have on the employee and the group.

Concentrated study will be made of four typical short term hospitals with open, but highly specialized, medical staff and voluntary community boards of trustees and which do not operate medical schools.

Association Reorders Supply of Job Description Manual

The American Hospital Association has obtained another supply of "Job Descriptions and Organizational Analysis for Hospitals and Related Health Services," which members may now order.

Shortly after the announcement that the book was off the press, the Association's initial supply of 1,000 copies was depleted.

The book is the result of more than two years of work by the U. S. Employment Service of the Department of Labor and the Association. It is the first comprehensive compilation of descriptive data concerning hospital occupations.

The manual is a tool that can guide hospital management in organizational and staffing problems by defining jobs and their place in the hospital as well as spelling out the qualifications of training and experience required by persons performing the jobs.

New Medical Gas System Goes Into Effect Soon

A new system for preventing erroneous interchange of medical gas cylinders will be put into effect this fall.

The system, worked out by the Compressed Gas Association, the American Hospital Association and the American Society of Anesthesiologists, consists of matching pins and holes on the gas appliances. The pins are installed in a special adaptor mounted on the cylinder yoke of the hospital's anesthetic gas machine, and the holes are drilled in the body of the valve that comes with the cylinder. For any one gas there is only one combination of pins and holes. Unless the right gas cylinder is connected, the holes and pins will not match and the two parts will not fit together.

All manufacturers will start drilling holes on the cylinder valve stocks on August 1 of this year, and after January 1, 1953, no more undrilled cylinders will be shipped to hospitals. After May 1953, manufacturers will start adapting anesthetic equipment.

MEDICAL GAS administration will be much safer when hospitals adopt the new system of non-interchangeability of cylinders as explained in the above American Hospital Association exhibit. Shown with the exhibit is Leonard P. Goudy, secretary of the Association's Council on Administrative Practice. This exhibit will be shown at many hospital meetings during the coming year, having made its debut at the New England Hospital Assembly last month. The system, described in HOSPITALS for August 1951, has the approval of the A.H.A., the American Society of Anesthesiologists and the Compressed Gas Association.

New Contest Deadline Set for July 1

A feature of the 1952 convention of the American Hospital Association will be the "Stretching Your Hospital Dollar" contest, in which all Association member hospitals are eligible to participate.

The purposes of the contest are to recognize and reward hospital people who have put into practice new ideas, better methods, labor-saving devices or administrative techniques: to effect internal economy and improve patient care, and as a means of exchange of ideas among hospitals.

All member hospitals may submit one or more entries. The entry deadline is July 1.

Preliminary judging of the entries will be done by the Association's Committee on Convention Program Planning. Final judging will be during the convention in Philadelphia September 15-18.

Government bonds will be awarded to the three top entries.

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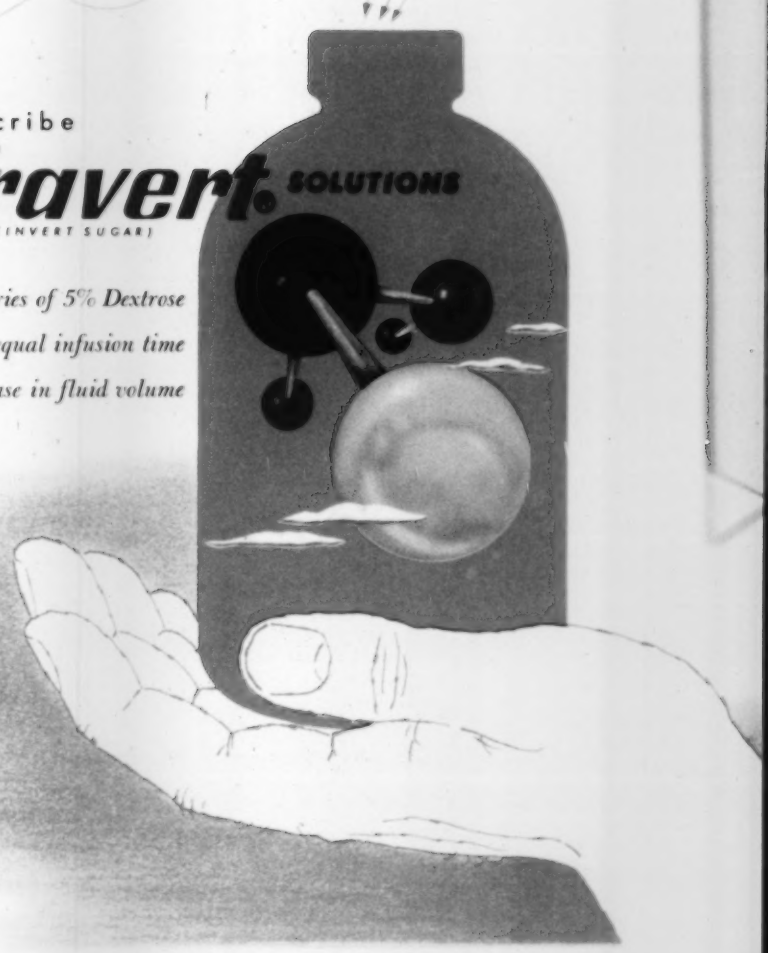

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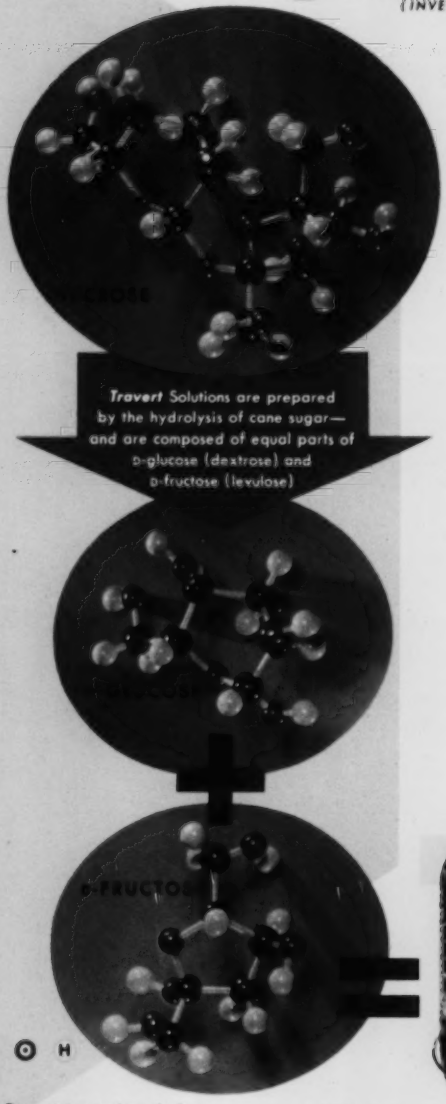

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Protestant Convention Draws 1,000

The thirty-first annual convention of the American Protestant Hospital Association February 21-22 in Cleveland brought together more than 1,000 delegates from all parts of the United States.

John G. Dudley, administrator of Memorial Hospital, Houston, Texas, was installed as president to succeed Leo M. Lyons, administrator of St. Luke's Hospital, Chicago. Lee S. Lanpher, administrator of Lutheran Hospital in Cleveland, was chosen as president-elect.

Other new officers for the coming year are: First vice president, C. E. Copeland, administrator of Missouri Baptist Hospital, St. Louis; second vice president, Lt. Col. Florence Turkington, the Salvation Army, New York City, and treasurer, L. B. Benson, D.D., administrator of Bethesda Hospital, St. Paul, Minn.

Albert G. Hahn, administrator of Protestant Deaconess Hospital, Evansville, Ind., is executive director of the association.

Several important resolutions were passed by the association during its two-day meeting. Included were resolutions:

1. That all member hospitals participate and cooperate in national and local civil defense activities, and that each institution organize its personnel and resources in order to be ready at all times to give maximum care if and when called upon.

2. That the convention encourage all boards and administrators of member hospitals to give increasing special attention to the introduction of improved techniques of administration, so that hospital resources may be utilized more efficiently and that the care of the sick may be improved.

3. That the members of the association focus attention upon the improvement of their nursing service through intensive study of principles of organization applicable to the unit; that the association's members develop an efficient administrative pattern for the nursing department, directed by sound policies and made effective through defined procedures at all levels of authority; that such a pattern should include professional and non-professional staff members whose responsibilities to the hospital and the patient are clearly outlined.

Meeting jointly with the American Protestant Hospital Association were the Association of Protestant Hospital Chaplains and other denominational groups.

Well-know speakers at the convention included Dr. Malcolm T. MacEachern, director of professional relations of the American Hospital Association. His topic was "Standards and Professional Relationships." On the same program were Guy J. Clark, executive secretary of the Cleveland Hospital Council, who spoke on "Organizing Community Hospital Councils and Hospital Finance," and Charles G. Lavin, assistant chief of the Division of Civilian Health Requirements, Public Health Service, who told members how to secure critical building materials and supplies. Albert V. Whitehall, director of the American Hospital Association's Washington Service Bureau, was another speaker. His subject was "Washington Reporting Today and for Tomorrow."

Among the denominational groups holding conventions at the same time as the American Protestant Hospital Association were the Episcopal Hospital Assembly, the National Association of Methodist Hospitals and Homes, the Lutheran Hospital Association, the Southwide Baptist Hospital Association, the Presbyterian Hospital Administrators, the American Baptist Association of Homes and Hospitals, and the Salvation Army.

Tuberculosis Group to Award Will Ross Medal Annually

The National Tuberculosis Association has announced it will present a medal annually to the person who has contributed most to the control of tuberculosis outside the medical field. The award will be made in honor of the late Will Ross, who was a national leader in the fight against tuberculosis and who was a former president of the National Tuberculosis Association.

Dr. Alton S. Pope, president of the tuberculosis association, said the first award of the Ross Medal will be made at the association's annual meeting in May in Boston. The Trudeau Medal, previously awarded for medical or nonmedical achievement in the battle against tuberculosis, now will be

LEE S. LANPHER (left), administrator of Lutheran Hospital in Cleveland, and John G. Dudley, administrator of Memorial Hospital in Houston, Texas, exchange congratulations at the annual convention of the American Protestant Hospital Association. Mr. Lanpher was chosen president-elect of the association, and Mr. Dudley was installed as the new president.

given only for work in the medical field.

Mr. Ross, who died May 31, 1951, contracted tuberculosis when he was a young newspaperman in Wisconsin. After his recovery, he entered the hospital supply business in Milwaukee.

Two Hospital Bills Passed in Massachusetts

Gov. John S. Fine of Massachusetts has signed two hospital appropriation bills in the full amounts provided by the 1951 session of the legislature.

The nurses training bill became effective January 19. It provides $1,300,000 during the current biennium for training student nurses. The rate of yearly payment for student nurses now is $150, or double the rate previously provided.

Earlier in January, the governor signed another bill which appropriates $15,993,200 for payment to 184 hospitals for service to indigent inpatients. The maximum daily reimbursement rate fixed by this act is $6.50, an increase of 50 cents.

Total increase in appropriations under the two bills amounts to $2,427,600. In addition, the 1951 session made a deficiency appropriation of $440,000 for training student nurses, so that $17,733,200 has been provided for hospitals as compared to $14,865,600 at the beginning of the 1949-1951 biennium.

Health Series Televised

A half-hour television program designed to show the health services, the care of patients, the teaching and research facilities of the Ohio State University Health Center, Columbus, was launched in mid-February by Station WBNS-TV and the health center. It is entitled "Picture of Health."

The series includes film sequences shot inside the center by the television station's film staff and the Ohio State University Department of Photography. The film passages are worked into live dialogue between the host of the program and a member of the center's faculty who specializes in the topic under discussion.

Programs in February and March dealt with work of the emergency room service, x-ray, anesthesia, service to patients, nursing service and education. Other programs being planned concern obstetrics, social service, physical medicine, cancer, out-

DR. JOSEPH MORTON (left), assistant radiologist at Ohio State University Health Center, explains x-ray equipment to Richard H. Bell, research associate in radio education at the university and the narrator of a current series of televised health shows.

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patient service, and industrial medicine.

5,000 Attend 29th Annual New England Assembly

Instructive sessions and technical exhibits covering every phase of hospital operation were included in the 29th annual meeting of the New England Hospital Assembly March 24-26 in Boston.

More than 5,000 hospital administrators, trustees, doctors, nurses, and staff members attended the meetings that dealt with subjects ranging from relations with group hospitalization plans to improving public relations.

Included on the program were discussions by speakers and panels on the admitting office, third party payments, human relations and the future of institutional-professional relationships. Among the speakers was Albert Deutsch, well-known medical writer.

Also on the program was a treatment of the philosophy of hospital organization by Edward K. Warren, president of the Greenwich (Conn.) Hospital Association; Dr. Martin R. Steinberg, director of Mt. Sinai Hospital, New York City, and Dr. Anthony J. J. Rourke, president of the American Hospital Association.

Current problems of central supply, dietetics, housekeeping, purchasing economy, small community hospitals, laundry, intramural education, hospital safety, operating room techniques and hospitalization of servicemen's dependents were explored.

The nursing section featured Marion W. Sheahan, National Committee for Improvement of Nursing Service, New York, and Marion J. Wright, associate director of Harper Hospital, Detroit. Mrs. Abraham E. Pinanski, chairman of the American Hospital Association's Committee on Women's Auxiliaries, headed a panel on auxiliary programs and problems.

Manufacturers of medical equipment and supplies filled more than 100 booths with exhibits of their products.

At HOSPITALS' press time, new officers of the assembly had not been elected.

Accounting Institute Planned

The 10th annual Institute of Hospital Accounting, sponsored by the American Association of Hospital Accountants at Indiana University, Bloomington, is being planned for July 13-18.

The institute this year will have a potential accommodation of 200, according to Frederick C. Morgan, secretary-treasurer of the American Association of Hospital Accountants. Last year's institute was attended by 129 members from 30 states and Canada. Because of space limitations, 40 applicants had to be turned down.

"We fully expect that we will have another 'sell-out' this year," Mr. Morgan said.

Key of Merit Winners Chosen

The 1952 winners of the Key of Merit have been chosen by the four states participating in the Tri-State Hospital Assembly, which presents the award annually.

E. C. Moeller, administrator of Lutheran Hospital, Fort Wayne, has been chosen "man of the year" for the state of Indiana. He is a past president of the Indiana Hospital Association.

The 1952 recipient from Michigan will be Sister Carmelita Man-

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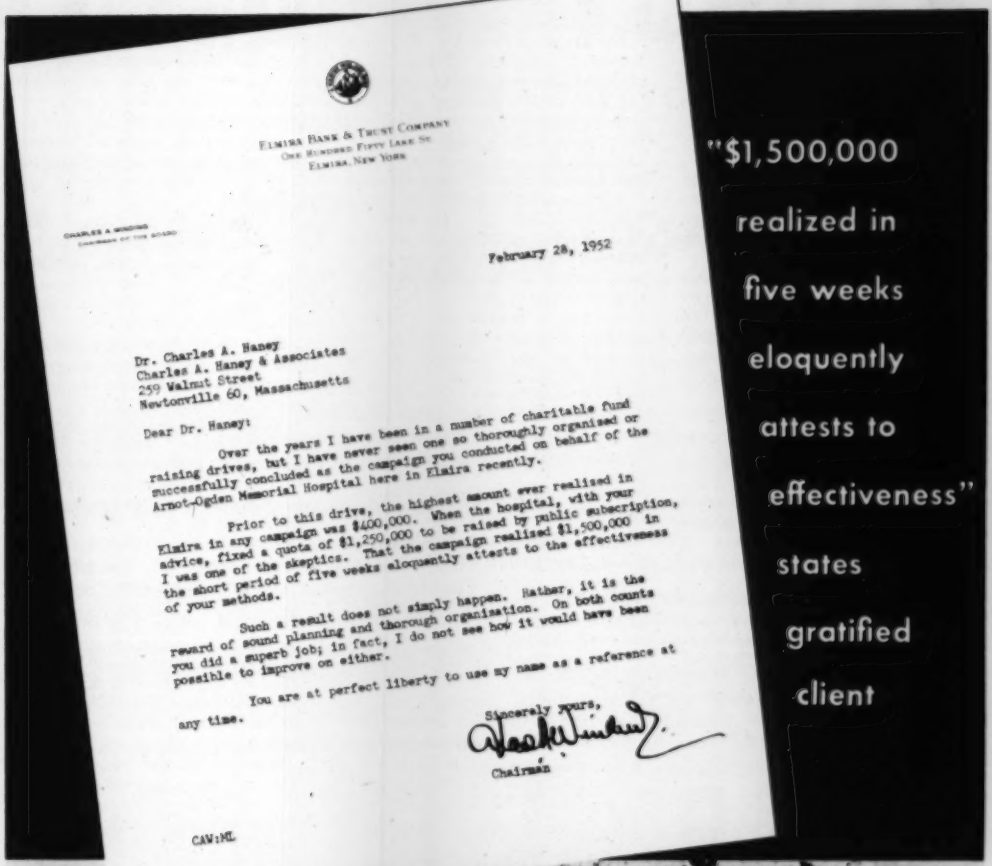

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CHAIRMAN OF THE BOARD

February 28, 1952

Dr. Charles A. Haney
Charles A. Haney & Associates
259 Walnut Street
Newtonville 60, Massachusetts

Dear Dr. Haney:

Over the years I have been in a number of charitable fund raising drives, but I have never seen one so thoroughly organized or successfully concluded as the campaign you conducted on behalf of the Arnot-Ogden Memorial Hospital here in Elmira recently.

Prior to this drive, the highest amount ever realized in Elmira in any campaign was $400,000. When the hospital, with your advice, fixed a quota of $1,250,000 to be raised by public subscription, I was one of the skeptics. That the campaign realized $1,500,000 in the short period of five weeks eloquently attests to the effectiveness of your methods.

Such a result does not simply happen. Rather, it is the reward of sound planning and thorough organization. On both counts you did a superb job; in fact, I do not see how it would have been possible to improve on either.

You are at perfect liberty to use my name as a reference at any time.

Sincerely yours,

Chairman

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ning, R. S. M., Sisters of Mercy, Provincial House, Detroit. She now is in charge of construction for the Mercy Order.

The recipient from Illinois will be L. C. Vonder Heidt, administrator of the West Suburban Hospital, Oak Park. Joseph G. Norby, administrator of the Columbia Hospital, Milwaukee, has been chosen to receive the Wisconsin key. He is a former president of the American Hospital Association.

The awards are given annually to the four persons who have made outstanding contributions to the hospital field. The keys will be presented at the annual Tri-State banquet on April 29 at the Palmer House in Chicago.

Philadelphia Council Holds Quarterly Meeting

The quarterly meeting of the Hospital Council of Philadelphia February 13 provided the occasion for bringing together the presidents and executive officers of three important health organizations on the Atlantic coast.

Represented were the Hospital Council of Philadelphia, the Associated Hospital Service of Philadelphia, and The Johns Hopkins Hospital, Baltimore.

Principal speaker at the meeting was Dr. Edwin L. Crosby, president-elect of the American Hospital Association and director of The Johns Hopkins Hospital. W. Frank Roberts, president of The Johns Hopkins Hospital, was at the meeting also. He is a member of a special committee to consider the permanent organization of a Baltimore hospital council with trustee and administrator representatives.

Also present at the meeting were Thomas S. Gates, Jr., president of Associated Hospital Service of Philadelphia, the Blue Cross plan in the area, and E. A. van Steenwyk, executive director of the plan.

Gordon A. Hardwick, president of the Graduate Hospital of the University of Pennsylvania, recently was elected chairman of the hospital council, which conducts a program of service in administrative practices and community relations for its 63 member institutions.

C. Rufus Rorem, Ph.D., is executive director of the council.

Regional Associations Make Final Convention Plans

Advance programs have been received from the Tri-State Hospital Assembly and the Mid-West Hospital Association, both of which will hold their annual meetings this month.

"Tomorrow's Hospital" will be the theme of the 24th annual convention of the Mid-West association, scheduled for April 23-25 in Kansas City. Top-flight speakers from the Midwest, as well as from outside the area, will be available throughout the week to assist with administrative problems.

An American Hospital Association institute on public relations April 21-22 will precede the convention.

In addition to the general meetings, sectional meetings will be held on housekeeping, the operating room, the small hospital, hospital auxiliaries, the medical record library and dietetics.

The association expects this year's exhibit of hospital equipment and supplies to be the largest in its history.

Tri-State Assembly: Dr. Anthony J. J. Rourke, president of the American Hospital Association, will be the banquet speaker during the 22nd annual Tri-State Hospital Assembly April 28-30 at the Palmer House in Chicago.

Dr. Rourke also will preside at a forum on the "New Plan of Accreditation of Hospitals" for all groups and sections of the assembly. The 34 chairmen of the Tri-State sections will be on the platform as expert consultants when questions arise concerning their special field of work in the hospital.

Speakers on the general theme "Meeting the Challenge for Service" at the opening general assembly will be Joseph G. Norby, administrator, Columbia Hospital, Milwaukee, Wis., who will discuss "Quality of Service—What Are Its Ingredients?"; Ernest I. Erickson, superintendent, Augustana Hospital, Chicago, "Care for All Types of Patients—Is Integrated Community Planning Feasible?"; Roy Hudenburg, secretary, Council on Hospital Planning and Plant Operation of the American Hospital Association, "Hospital Responsibility for Patient Safety"; and Anthony Eckert, director, Perth Amboy (N.J.) General Hospital, "Hospital Responsibility to the Public in Emergencies—Industrial Disasters, Floods, Tornadoes, Wrecks, Civil Defense."

"Human Relations" will be the theme of the Tuesday morning general session. Among the speakers will be Dr. Kenneth Babcock, director of Grace Hospital Detroit, and Dr. J. J. Moore, Chicago.

"Obtaining Adequate Nursing Personnel," a panel discussion, will be one of the subjects under the

AMONG THOSE present at the recent meeting of the Hospital Council of Philadelphia were representatives of three eastern health groups. From left are: W. Frank Roberts, president, Johns Hopkins Hospital, Baltimore; E. A. van Steenwyk, executive director of Associated Hospital Service of Philadelphia; Thomas S. Gates Jr., president, Associated Hospital Service of Philadelphia; Gordon A. Hardwick, chairman, Hospital Council of Philadelphia; Dr. Edwin L. Crosby, director, Johns Hopkins Hospital and president-elect of the American Hospital Association, and C. Rufus Rorem, the executive director of the Hospital Council.

CUT-UP TURKEY

Cuts cooking time and portion costs

"Cooking time and stove and storage space can be substantially reduced and yield increased by a new method of cooking turkey called the braising and simmering method," says Col. Paul P. Logan, Director of Food & Equipment Research, National Restaurant Assn. The *braising* process can be accomplished in the oven or on top of the range in 1½ hours, regardless of the size of the bird (compared with 4 to 6 hours the conventional way). The simmering of the non-sliceable parts can be done in the same length of time in a steam jacket or on the top of the range.

Among the benefits gained by this method of turkey cookery are these:

- ★ **Both tender and less tender parts are cooked uniformly . . . there is no drying out of the more tender parts while bringing the less tender parts to perfection.**
- ★ **Several turkeys can be cooked in a single turkey pan thus conserving range and storage space.**
- ★ **Kitchen labor is conserved.**
- ★ **More sliceable portions are obtainable.**
- ★ **Breasts, thighs and other sliceable parts can be either hand-sliced or machine-sliced to get more satisfactory portions with less labor.**
- ★ **Test panels prove that flavor is excellent — like the finest whole roasted turkey, or better.**

For complete yield studies and instructions on how to cut up and cook turkeys this new way, write for new booklet: "Cut-up Turkey Cookery." This is only one good way to cook turkey. There will always be whole roast turkey. And remember: Turkey is Always in Season.

NATIONAL TURKEY FEDERATION

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NATIONAL TURKEY FEDERATION
Mt. Morris, Illinois

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general theme "Planning for the Future" at the Wednesday morning general assembly. The moderator will be Marion Fox, nursing specialist of the American Hospital Association. Also speaking at the Wednesday morning session will be Graham L. Davis, director of the Commission on Financing of Hospital Care, Chicago, who will discuss "Costs in Line With Service —Can They Be Controlled?" The need for care of chronically ill, geriatric, and polio patients in general hospitals will be discussed by a representative of the Commission on Chronic Illness.

Ray E. Brown Elected Head of Chicago Hospital Council

Ray E. Brown, superintendent of the University of Chicago Clinics, was elected president of the Chicago Hospital Council at a meeting in Chicago February 27.

Other officers elected for the coming year are: President-elect, Ralph M. Hueston, superintendent of Wesley Memorial Hospital; vice president, Edna H. Nelson, administrator, Women's and Children's Hospital; and secretary-treasurer, the Rev. Joseph M. George, administrator of Evangelical Hospital. Elmer E. Abrahamson, secretary of the board of trustees, Norwegian-American Hospital, was re-elected chairman of the board of directors.

Elected members of the council's board of directors were: Franklin B. Snyder, president of the board of trustees, Presbyterian Hospital; Dr. Stephen Manheimer, director, Mt. Sinai Hospital; the Rt. Rev. Msgr. John W. Barrett, director of Catholic hospitals, archdiocese of Chicago; Edison Dick, president, board of trustees, Passavant Memorial Hospital; Stanley P. Farwell, treasurer, board of trustees, Provident Hospital; Charles J. Hassenauer, superintendent, Garfield Park Community Hospital, and Leo M. Lyons, director of St. Luke's Hospital.

Foley, MacEachern to Address Indianans

C. J. Foley, associate editor of HOSPITALS, and Dr. Malcolm T. MacEachern, director of professional relations for the American Hospital Association, will be principal speakers at the annual convention of the Indiana Hospital Association June 13 at Indianapolis.

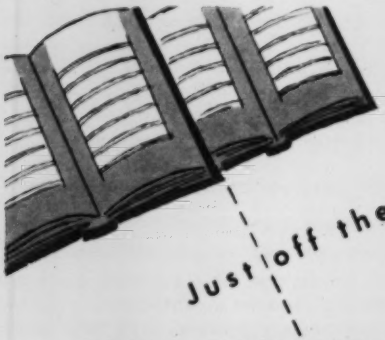
Mr. Foley will speak on "Public Relations" at the morning session, which also will include a panel discussion on "Public Relations That Bring Results." Moderator will be President-elect Edmund Shea, assistant administrator of the Indiana University Medical Center, Indianapolis. Discussants will be: Ralph W. Keyes, administrator, Jackson County Schneck Memorial Hospital, Seymour; George R. Wren, adminstrator, Methodist Hospital, Gary; Sam Virts, public relations director, St. Mary's Hospital, Evansville, and Marc Waggener, director, news bureau, Indiana University Medical Center.

The subject of Dr. MacEachern's talk in the afternoon session will be "Human Attitudes in the Hospital."

Western Kentucky Group Meets

Walter C. Byers, superintendent of the Jennie Stuart Memorial Hospital, Hopkinsville, was elected president of the Western Kentucky Hospital Council at the council's February meeting.

Other officers elected are: Vice



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president, Carl Wieler, administrator of Hopkins County Hospital, Madisonville; secretary, C. N. Hatcher, superintendent of the Owensboro-Daviess County Hospital, Owensboro, and treasurer, Helena Hughes, administrator of Riverside Hospital, Paducah.

Eighteen hospitals in western Kentucky are members of the council.

Georgia Association Elects E. R. Barton President

Eric B. Barton, administrator of Griffin-Spalding Hospital, Griffin, was installed as president of the Georgia Hospital Association at its annual meeting February 15-16 in Atlanta.

Oscar S. Hilliard, administrator of the Athens General Hospital, was selected as president-elect, and James W. Brown Jr., purchasing agent of Grady Memorial Hospital, Atlanta, was re-elected treasurer.

Delegate and alternate to the American Hospital Association are Fred M. Walker, assistant superintendent of Grady Memorial Hospital, and W. N. Walters, administrator of Hall County Hospital, Gainesville.

The association voted to send a resolution to Gov. Herman Talmadge requesting relief from Georgia's 3 per cent sales tax for the nonprofit hospitals of the state. Several of the neighboring states —Alabama, Tennessee, Florida and North Carolina—have exempt their hospitals from sales tax and eventually Georgia hopes to gain the concession.

At the Saturday morning business session, the association made plans to strengthen the Association during the coming year by adding personal members, by bringing in the Blue Cross groups for more active support, and by sending out various questionnaires on matters of general interest.

Clearinghouse Service Begun

A clearinghouse service on competent, ethical technicians specializing in braces, limbs, plastic eyes or facial and body prostheses is being established by the Academy-International of Medicine, Topeka, Kan.

Qualified dentists doing obturator work or plastic eyes are included. Information will be available to all members of the medical profession on request. Names and addresses of qualified technicians and dentists should be forwarded to Academy-International of Medicine, 214 W. Sixth Street, Topeka, Kan.

Sister Eucharia Elected Head of Arizona Association

Sister Mary Eucharia, superintendent of St. Joseph's Hospital, Phoenix, was elected president of the Arizona Hospital Association at the annual convention February 15-16 in Phoenix.

Joseph Coppa, manager of the Mohave General Hospital, Kingman, was elected first vice president, and Guy M. Hanner, administrator of Good Samaritan Hospital, Phoenix, was re-elected secretary.

Mr. Hanner and William S. Weeks, director of Tucson Medical Center, were elected delegate and alternate, respectively, to the American Hospital Association.

Approximately 100 persons attended the two-day meeting.

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Pennsylvania Plan Joins Bank, Adds to Enrollment

Capital Hospital Service, Inc., Harrisburg, Pa., will begin participating in the Inter-Plan Service Benefit Bank on April 1. Seventy-nine of the 87 approved Blue Cross plans will be participating in the bank at that time.

The participating plans represent 86.76 per cent of the total Blue Cross enrollment as of December 31.

During the first month of 1952, Blue Cross payments to member hospitals in the central Pennsylvania area amounted to $502,423.35 for the care of 5,341 hospitalized members.

The January figure was 26 per cent higher than the corresponding figure for January of 1951, reported Clement M. Hunt, executive director of Capital Hospital Service, the plan serving the central Pennsylvania area.

Late in February, it was announced that the Atlas Powder Company in Pennsylvania and the Reading Company had authorized payroll deductions for Blue Cross and Blue Shield for all employees.

The Atlas Powder Company will be assuming costs of medical and hospital care for about 1,300 employees at the dynamite plant, blasting supplies works and experiment laboratory in Reynolds and at the dynamite plant in White Haven.

The Reading Company action will affect about 19,000 employees of the railroad in the tri-state area of Pennsylvania, New Jersey and Delaware. Four Blue Cross plans and two Blue Shield plans in the three states have pooled their services to provide the coverage.

Blue Shield Enrollment Totals 21,125,812

The 78 Blue Shield plans added a total of 4,496,216 new members during 1951, the highest yearly increase to date. Enrollment in the 78 plans on December 31 was 21,125,812.

Medical Service Association of Pennsylvania, Harrisburg, led all Blue Shield plans in growth for 1951 with a net increase of 717,630 new members. United Medical Service, New York City, was second with 520,159.

Based upon the percentage of population enrolled in the areas served by the Blue Shield plans, Group Hospital Service, Inc., Wilmington, Del., leads all plans with one out of every two persons in its area enrolled.

Blue Cross Plans Enroll 2,210,269 in 1951

With the addition of 2,210,269 members during 1951, enrollment in the 87 Blue Cross plans reached a total of 41,435,379 on December 31.

Blue Cross now has enrolled one of every four persons residing in areas of the United States and Canada served by the plans.

The largest annual net gain in membership was achieved by the Associated Hospital Service of New

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Easy **on skin surfaces. Here is quality cellulose tissue at its best. The soft, fibredown feel and texture of S'WIPE'S will appeal to the most fastidious... their extra absorbency will serve in every practical occasion.**

Easy **on the budget. Available packages in three practical sizes and nine different quantity counts mean a marked reduction in waste and expense. For that extra economy, check also on our bulk quantity offer, either flat or folded.**

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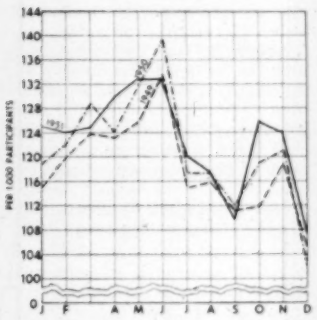
York, New York City, with a growth of 440,842 new members during 1951. Michigan Hospital Service, Detroit, with a gain of 270,039, was second in enrollment gains for the past year

The Hospital Service Plan of Lehigh Valley, Allentown, Pa., is the leader among plans in percentage of population enrolled. The Allentown plan had 76 per cent of its population enrolled on December 31. Hospital Service Corporation of Rhode Island, Providence, was second with 75 per cent.

HOSPITAL ADMISSIONS



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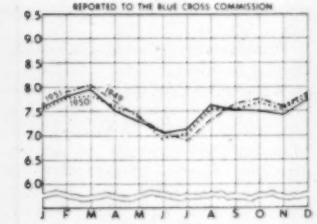

ADMISSION-STAY

The annual rate of admissions of Blue Cross members to hospitals rose to 131 per 1,000 participants during January 1952. This is an increase of 24 per 1,000 over the December 1951 rate. The January 1951 admission rate was 125 per 1,000 participants.

The average length of stay of hospitalized members for December 1951 was 7.72 days, a slight increase over the previous month's average of 7.42 days. The average length of stay during December 1950 was 7.74 days.

Inpatient days of care provided by Blue Cross during December 1951 averaged 893 per 1,000 participants. The previous month's average was slightly lower—890 days. In December 1950 the average number of inpatient days of care provided was 886.

Cincinnati Plan Reports Record-Breaking Year

Hospital Care Corporation, Cincinnati, announces 1951 was a record-breaking year for payments.

During the year, nearly $10,500,000, or more than 93 cents of every dollar of income, was used to pay for hospital bills of the plan's members. Less than 6 cents of every dollar was used for operating expense. A total of 130,000 hospital bills, covering more than 800,000 days of hospital care, was paid.

Accidents and injuries were the leading cause of hospitalization among members, the plan reports. That cause accounted for about one-fourth of all hospital admissions. Maternity care was the second leading cause of hospitalization and set the highest yearly rate in the area's Blue Cross history—almost 24,000 births.

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Stricter Practical Nurse Laws Urged

Enactment of stricter and more uniform state laws governing the field of practical nursing to protect the public from unqualified practitioners was urged here today by the National Association for Practical Nurse Education.

Only five states in the country and Hawaii now have laws requiring practical nurses to obtain licenses before they can be employed. In 29 other states and in Puerto Rico, the law permits the practical nurse to work even if she fails to qualify for a license. Fourteen states have no licensing laws at all.

"Clear cut legislation, such as the New York State law, which makes it a criminal offense for the practical nurse to work without a license, is the only step that will protect the public," said Hilda M. Torrop, executive director of the National Association for Practical Nurse Education. "In states with so-called 'permissive' laws, however, it is just the nursing title that is protected by legislation, which is certainly no safeguard."

According to the association, there is an immediate need today for 60,000 trained practical nurses to provide important nursing service throughout the country, but only 8,000 students now are attending 200 approved schools.

Grant of $18,000 Furthers Practical Nurse Training

A grant of $18,000 to the Illinois board of vocational education for the promotion of practical nurses training, has been made by the W. K. Kellogg Foundation.

The money will be used to add a state supervisor of practical nursing to the board's staff.

Practical nurse education under public auspices is now carried on in Illinois in Chicago schools. The state board of vocational education is planning, with the help of the new supervisor, to set up several training centers in other parts of the state. In 1952-53, it expects to establish more centers for preparatory training.

Nurse Shortage Still Exists

There are more professional registered nurses actively engaged in nursing today—a total of 322,500—than ever before in the history of the United States, yet their ranks are below the desirable minimum, reports the Hospital Council of Greater New York.

It is estimated that 65,000 additional professional registered nurses are required immediately to meet the essential civilian demands in hospitals, schools of nursing, public health, industrial, private duty and other fields. Another 4,000 are wanted by the Army and Air Force Nurse Corps, and the Navy.

A study made in May 1951 by

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the Health Resources Advisory Committee of the Office of Defense Mobilization states that by 1954 civilian nursing services alone will require 379,500 nurses, and, if the armed forces reach a strength of 5,000,000 men, they will need an additional 25,000 nurses—a total of 404,500.

Since nursing schools graduate only about 30,000 each year, and 22,000 are lost from the ranks of graduate nurses annually—chiefly by marriage—there will be only 24,000 more nurses by 1954 instead of the estimated additional need of 82,000. This represents an actual deficit of 58,000 for civilian and armed forces requirements.

Public Relations Head Named for Nurses' Association

Mrs. Jane Jordan Rogers has been appointed public relations director of the American Nurses' Association succeeding Mrs. Jane Bochat.

Mrs. Rogers at one time was public relations director of the National Organization for Public Health Nursing. She has handled membership promotion for the National Association of Manufacturers and during World War II was in public relations work with the Army and the Office of Price Administration.

New York Nursing Director

Dorothy Weddige has been appointed director of the City of New York Department of Hospitals' nursing education and nursing service, it has been announced by Dr. Marcus D. Kogel, commissioner of hospitals.

As director of nursing education and nursing service, Miss Weddige will head a nursing force of 13,000 nurses, practical nurses and hospital attendants in the 33 municipal hospitals and homes. In addition, she will direct the operation of 12 schools of nursing, which have an annual enrollment of more than 2,000 students.

Head Nurses Conferences Scheduled for Spring

Five working conferences on an analysis of the activities of the head nurse will be conducted in April and May.

The two and one-half day conferences will be sponsored by the American Hospital Association, the National Committee for the Improvement of Nursing Services and the Public Health Service.

The dates of the conferences are:

Cleveland—April 2-4
St. Louis—April 16-18
New Orleans—April 21-23
Salt Lake City—April 28-30
Washington, D. C.—May 5-7

The method of analysis has been designed by the Division of Nursing Resources of the Public Health Service, and the working conference instruction will be provided by that group. Persons who will direct head nurse studies in their own hospitals, state hospital nursing consultants, and faculty members from universities conducting programs in nursing service administration are eligible to attend the conferences.

Those interested may write the National Committee for the Improvement of Nursing Services, 2 Park Avenue, New York 16, for attendance blanks and further information. There will be no conference fee for those who attend the meeting.

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Hospital Scores High in Opinion Poll

A report recently released by the Opinion Research Corporation, Princeton, N. J., on the results of a patient opinion poll taken at Princeton Hospital shows that only 14 per cent of the 148 patients polled said they thought hospital charges were too much.

The purpose of the research, conducted among patients discharged from the hospital between October 1 and October 31 of last year, was to measure patients' satisfaction and dissatisfaction with the various aspects of service at Princeton Hospital.

The research showed that about 89 per cent of the patients rated the over-all service at the hospital good, and none gave it a poor rating. The highest praise on specific aspects of hospital service was given to nursing staff, with food and the friendly atmosphere also being given favorable ratings.

Among the criticisms, complaints about food were most numerous. Noise, attributed chiefly to other patients, was second.

George Bugbee, executive director of the American Hospital Association, said the study was, to his knowledge, "among the few, if not the only, scientifically conducted patient opinion polls conducted for a hospital by a nationally recognized opinion research organization."

The results, he said, show that "hospitals are often too apt to assume that a highly vocal minority opinion is the reflection of general public attitude." He added that through such a poll hospitals could measure more accurately the feeling of the community towards them.

The research project was begun last summer by the board of trustees of the hospital.

John W. Kauffman is superintendent of the hospital.

Hospital Named Beneficiary

Deaconess Hospital, Spokane, Wash., was named recipient of $500,000 in downtown Spokane real estate from the estate of Franklin P. Sherwood, a mining engineer, who died in January.

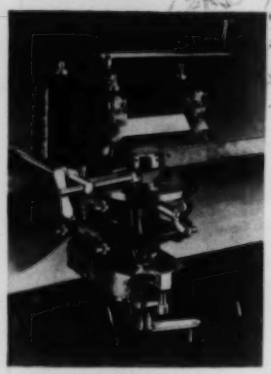
The hospital will receive the properties after the death of Jennie D. Sherwood and Howard C. Sherwood, sister and brother of the late Mr. Sherwood.

The bequest was made in memory of John Dickinson Sherwood, a former resident of Spokane. The hospital, under the will, is to erect a memorial to him.

Knickerbocker Hospital Offers Diagnostic Test "Package"

Knickerbocker Hospital, New York City, has announced a subsidized laboratory system which it hopes will bring the cost of diagnostic tests within the means of persons with middle-size incomes.

Since January 1, the hospital has made available to any person through his own physician a



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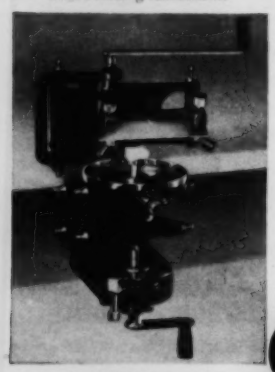

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"package" deal in which any number of diagnostic tests are made for a maximum of $40, including tests that run as high as $60 to $100 elsewhere.

The service was designed to meet two needs, explained L. B. Dana, administrator of the hospital. These are:

1. The needs of persons with moderate incomes for this type of service at prices they can afford.

2. The need of general practitioners not on hospital staffs for supplementary diagnostic tests. The hospital will make the tests and report results back to the patient's doctor, so the doctor can make his own diagnosis.

Lambertus R. P. Schoonheim, a trustee of the hospital, is providing the money for the service and is prepared to expand the hospital's facilities if they become inadequate. A larger waiting room has already been begun, Mr. Dana said.

Kellogg Grant Aids Instructors

A grant of $6,480 has been made to the National University of Mexico by the W. K. Kellogg Foundation.

The money is to be paid in annual installments over a three-year period and is to be used to provide monthly stipends of $20 to each of 10 faculty members of the graduate school who are instructors in a course on gastroenterology being given in connection with the Hospital for Nutritional Diseases, a government institution in Mexico City.

The instructors, several of whom are former holders of Kellogg Foundation international fellowships, have not been receiving pay for their services, in conformity with local custom. It is hoped that the foundation's assistance will be instrumental in establishing a precedent by which the university will accept responsibility for paying physicians who serve as instructors in courses of this type.

"Walking Blood Bank" Started at Huron, S. D., Hospital

The St. Johns Hospital Blood Bank of Huron, S. D., has instituted a program for an enlarged "walking blood bank."

The blood bank anticipates the blood needs of the community and keeps on hand a limited supply of blood of all types ready for immediate use. Emergencies, however,

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to help reduce bed falls

Both of these new Hill-Rom safety items can be used on any hospital bed—wood or metal. The Safety Side is attached to the head-end of the bed, and does not interfere with use of overbed table, nor with making up the bed. Above illustration shows its use for a cardiac case, enabling the patient to rest or sleep in an almost-sitting position.

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necessitate a supply of blood in larger quantities than can be kept in the blood bank from day to day.

A call for any amount of blood of any type is met immediately by the walking blood bank, which has a donor list of 450 persons. Donors are instantly summoned to the hospital through the American Red Cross facilities.

The Beadle County Walking Blood Bank, as it is called, accomplishes two definite purposes:

1. It maintains a small supply of blood of every type to take care of day-to-day needs.

2. It provides a means of supplying a larger quantity of blood to meet an emergency.

Dr. Candau Begins Duties at Pan American Bureau

Dr. M. G. Candau, recently appointed assistant director of the Pan American Sanitary Bureau, Regional Office of the World Health Organization, has arrived in Washington, D. C., to begin his new duties.

Dr. Candau resigned last December from his position as assistant director general of the World Health Organization, in charge of the Department of Advisory Services. He replaces Dr. Paulo C. A. Antunes, who resigned to become dean of the School of Hygiene and Public Health of the University of Sao Paulo, Brazil.

In his two years at W.H.O. headquarters in Geneva, Dr. Candau contributed to the development of W.H.O. policy and programs for advisory services to governments, particularly in the field of fundamental public health services.

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NEW INSTITUTIONAL MEMBERS

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DISTRICT OF COLUMBIA

Washington—Memorial Hospital Association of Kentucky, Inc.

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Miami—Mercy Hospital

ILLINOIS

Chicago—Commission on Financing of Hospital Care
Chicago—Welfare Council of Metropolitan Chicago
Dwight—The Keeley Institute

KANSAS

Kansas City—Providence Hospital
Larned—St. Joseph Memorial Hospital
St. John—St. John Veteran Memorial Hospital

LOUISIANA

Bogalusa—Pepe Clinic Hospital

MASSACHUSETTS

Boston—James H. Ritchie & Associates

MICHIGAN

Detroit—Sinai Hospital
L'Anse—Baraga County Memorial Hospital

MINNESOTA

Cloquet—Fond du Lac Indian Hospital

MISSOURI

Hayti—Pemiscot County Memorial Hospital
Lexington—Lexington Memorial Hospital
St. Louis—Missouri-Kansas-Texas Railroad Employes' Hospital Association

NEBRASKA

Neligh—Antelope Memorial Hospital

NEW JERSEY

Elmer—Elmer Community Hospital

NEW YORK

Hamilton—Community Memorial Hospital
New York—Francis Delafield Hospital

NORTH CAROLINA

Raleigh—The Budget Bureau
Windsor—Bertie County Memorial Hospital

NORTH DAKOTA

Grafton—St. Joseph's Community Hospital

OHIO

Euclid—Glencliff Hospital

OREGON

Myrtle Creek—Myrtle Creek Hospital

PENNSYLVANIA

Philadelphia—Wynnefield Hospital

SOUTH CAROLINA

Greenville—American Association of Hospital Consultants

SOUTH DAKOTA

Redfield—Community Memorial Hospital

TENNESSEE

Knoxville—East Tennessee Crippled Children's Hospital
Memphis—Carroll Turner Sanatorium

TEXAS

Alvin—Alvin Memorial Hospital
Austin—Brackenridge Hospital

VIRGINIA

Hot Springs—Community House Hospital
Leesburg—The Loudoun County Hospital, Inc.

WASHINGTON

Chewelah—St. Joseph's Hospital
Port Angeles—Olympic Memorial Hospital
Seattle—Washington State Hospital Association

WEST VIRGINIA

Buckhannon—Elizabeth Coplin Leonard Memorial Hospital
Charleston—Bolarsky Memorial Hospital Association

WYOMING

Cheyenne—State Department of Public Health

HAWAII

Honolulu—Division of Hospitals and Medical Care, Department of Health
Kaneohe—Territorial Hospital

PUERTO RICO

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Dodds, Arthur W.—Asst. Chief Phar.—U. S. Public Health Service Hospital—Norfolk, Va.
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Lee, Barbara Jeffery—Student of Hosp.-Adm.—Yale University—New Haven, Conn.
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Lewandowski, Edmund P.—Commissioner of Welfare Institutions—City of Cleveland—Cleveland, Ohio
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Lyons, William J.—Asst. Man.—Veterans Administration Hospital—Jackson, Miss.
Manrow, (Maj.) William E.—USAF (MSC) Chief of Adm.—Medical Plans and Hospitalization Division, Headquarters 15th Air Force, March Air Force Base, Calif.
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McFarlan, Theodore E.—Student of Hosp. Adm.—University of Pittsburgh
McLellan, Lt. David J.—MSC, USN, Med. Adm. Off.—Medical Department—Boston Naval Shipyard
Moran, Roy N.—Medical Records Off.—Air Surgeon's Office—Headquarters Strategic Air Command, Offutt Air Force Base—Omaha
Nicholson, Kenneth M.—Adm.—Jeffery Hale's Hospital—Quebec City, Quebec, Canada
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Walker, Garth — Ass't. Adm. — Jefferson-Hillman Hospital—Birmingham, Ala.
Weissmiller, L.L., M.D.—Dir.—Foundation Hospital—New Orleans, La.
Wickman, Waldemar J. A., M. D.—Chief, Outpatient Branch—Public Health Service—Washington, D. C.
Wilke, Mabel C.—Anesthetist—St. Agnes Hospital—Fond du Lac, Wis.

STANDARDIZATION

(Continued from page 61)

was frequently supplemented by additional pages. These long and wordy reports were often too lengthy for the busy hospital administrator to read and digest.

Finally, four years ago, the Point Rating System form of report was worked out and adapted to the survey of hospitals. This plan provides for a numerical evaluation of the organization and functioning of the hospital in each division and department. The 18-page report embraces two main divisions—Part I, Essential Divisions, or those considered necessary and which all hospitals must maintain in order to meet the requirements and be approved; Part II, Complementary Divisions, found in most large hospitals but not necessarily required in all institutions. These main divisions are broken down into departments or services embracing a further breakdown into a total of 115 main questions with numerous sub-headings. Points are allotted to each phase, making a total of 1,000 for a hospital embracing all the departments and services. In smaller hospitals where all the departments are not necessarily available, the total points allotted are proportionately less. After an experimental phase of trying it out in several hundred hospitals, this plan was adopted universally.

Some hospitals have found the Point Rating System of inestimable value as a means of self-evaluation and use it for this purpose through appointing a committee of five or six members representing the administration, the medical staff and the governing board to make the study of their own hospital.

PROGRESS 1918-1952

The first group of hospitals to be surveyed were those of 100 beds and over. The first survey in 1918 covered 692 hospitals of which 90 or 12.9 per cent were eligible for Approval. In 1950 we find 2,429 hospitals in this group under survey and 2,297 hospitals, or 94.6 per cent acceptable for approval..

The next group to be considered were hospitals of 50 to 100 beds which came under survey for the first time in 1922. In that year there were 812 hospitals in this category under survey and of this number 335 or 41.3 per cent met requirements. In 1950, there were 1124 hospitals in this class under survey and 790 or 70.5 per cent were accepted for approval.

In 1924, the third group of hospitals of 24-49 beds were placed

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under survey. Out of 307 surveyed, only 49 or 15 per cent met requirements. In this class in 1950, there were 468 hospitals surveyed and 203 or 43.3 per cent were found eligible for approval.

To summarize, we find that in 1918, there was a total of 692 hospitals under survey and 89 or 12.9 per cent met requirements. In 1950 there were 4,021 hospitals under survey of which number 3,290, or 82 per cent were included in the Approved List.

In 1952, there are 4,111 hospitals under survey and 3,352, or 81.5 per cent are on the Approved List. During the period of operation of Hospital Standardization, approximately 75,000 individual surveys of hospitals have been conducted at a cost of more than two million dollars to the American College of Surgeons.

These figures show notable progress in the 34 years of Hospital Standardization. There is still much to do in the years to come.

To say it was not easy in the early days of Hospital Standardization is putting it mildly. The larger hospitals were skeptical that the requirements were too minimal. They did not feel the movement would do them much good. The smaller hospitals feared they might not acquire recognition.

Some authorities advocated on A, B, C classification of hospitals, but the Board of Regents of the College believed there should be a Minimum Standard for all, above which hospitals could advance as far as they desired. They felt that a classification of hospitals in the categories mentioned would entail too much work and greater expense than the budget would allow, as well as possibly creating dissension among hospitals. They advocated the program of the Minimum Standard for all hospitals.

Although there were many problems in promoting Hospital Standardization with considerable opposition in some quarters, and skepticism in others, it is gratifying to know that there was early and rapid widespread influence of the movement. Hospitals soon began putting their institutions in order, so to speak, as standards became better known.

CURRENT PROBLEMS

Throughout the survey of hospitals certain continuing problems were noted.

It was difficult in many hospitals to organize the medical staff on a basis that would give adequate control and supervision of clinical work. The designations of chief of staff and chiefs or heads of departments were not always acceptable nor considered democratic. In the course of time, however, through the growth of specialization, this problem has been gradually disappearing. There is still a lack of adequate control and supervision of the clinical work in some institutions, but it is being overcome. The control of surgery has been a real difficulty but in recent years the introduction of the medical audit and the tissue committee have been valuable in improving the quality of surgery and preventing unnecessary and incompetent surgery.

It has been difficult to overcome the reluctance of doctors to frankly and fearlessly discuss their cases in conference and to get members of the medical staff to admit their own failures and errors. It is true it has taken time to break down this feeling on the part of some members of the medical staff. The general medical staff conference, the clinical departmental and the clinicopathologic conference have done much to control the quality of work and exert an educational influence on the medical staff. When there is a regular and thorough review and analysis of clinical work in the hospital there is a higher degree of scientific efficiency among the medical staff. More and more medical staffs are becoming aware of the value of conferences.

It is still claimed that there is much fee-splitting among physicians, and this of course, is an unethical practice. All physicians

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should obtain their clientele through merit rather than monetary or other emoluments and should be paid directly by the patient for services rendered.

The problem of keeping medical records is still evident in some hospitals. Members of the medical staff although well intentioned, frequently fail to meet this requirement despite the advantages it provides. Several means have been employed in helping the physician perform this function but there is still considerable failure to produce scientific medical records or those with sufficient data to justify the diagnosis and warrant the treatment and end results. The trained medical record librarian, the medical records committee and the medical audit have all been useful in the support of medical records.

While there are many other areas to be considered, the problems relative thereto are not too difficult. There is a shortage of nurses in many communities and some difficulties in maintaining the personnel required, but nurses aides and voluntary groups have relieved this situation somewhat.

It is true that the cost of hospital care today has risen to an unprecedented level and the financing of hospitals has been a major concern. Nevertheless, there has been no deterioration in services. We are now in a period of the better trained administrator and his talents and abilities make him capable of coping with many of the situations which arise. Efforts always have been directed towards better relations between hospitals and physicians through more intimate contact, conferences and the like. With a well-planned program of accreditation, better administrator-physician relations will be realized.

These are but some of the problems; there are certainly others, many of which already have been minimized as a result of Standardization. It is our job to continue minimizing them and to maintain an accreditation program of continuing effort and increasing scope. We will have such a program, for the foundations are set and the participating organizations are encouragingly determined.

PRN — PRO RE NATA

(To take as required)

BY JOHN H. HAYES

THE SUPPLY of blood apparently will never meet the demand.

This applies not only to Red Cross, but to hospitals and other suppliers as well.

This idea costs nothing—and is probably worth it—but if the federal and state income tax departments would allow taxpayers to include as charitable contributions blood donations, at, say $25 a pint, there might be many more donations. This might mean only $5 or $10 per donation in annual tax saving, but it's something. After all, the donation of a pint of blood is a charitable gift.

★ ★ ★

Perhaps the easiest way to make the interior of a hospital look like a hospital is to put up a lot of signs of the restrictive and directional types.

Most of us want our building to look like home, where one does not see signs (except, perhaps, in the room of a high school student).

But we have to have some. Each time I put one up, however, I try to find another that can be taken down.

Strange, but there are lots of people who, on seeing a "No Smoking" sign, immediately reach for a cigaret; and as for "Quiet" signs, you can find them in the noisiest places!

★ ★ ★

For many years we have published, every month or two, what we call "Bouquets." This is mimeographed, of one or more pages, and includes excerpts from letters of patients or their relatives complimenting us on our services. We do not use the names of our own people, when mentioned, but we do show the name of the patient and the area of the hospital in which he was treated.

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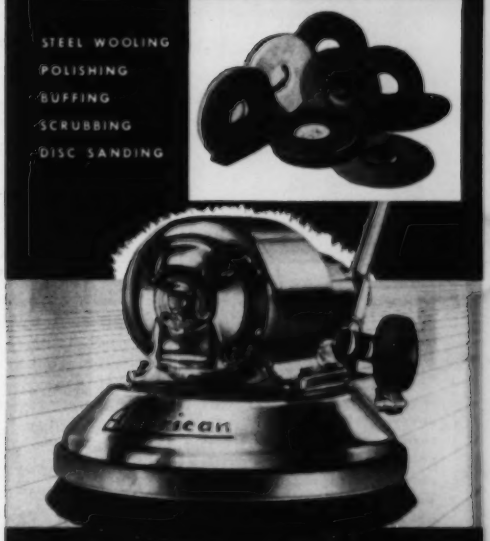

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the patient is recalled in each case and those who brought about the letter know of his appreciation.

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★ ★ ★

We folks above the Mason-Dixon Line are learning the poorest time of the year for trustee meetings is the first four months. Reason: A great many successful business men now take winter vacations.

I have suggested that we hold our board meeting in those months in Florida and have offered to go down to them (at hospital expense). Thus far, I have not been able to sell the idea.

★ ★ ★

Israel has more doctors in proportion to the population than any other country. I believe the United States comes next. That should mean that we have enough doctors. The difficulty is no doubt due to maldistribution.

★ ★ ★

I've heard of a dietitian who successfully feeds more than a thousand people each day and whose husband has stomach ulcers.

★ ★ ★

A doctor once said to me, "I'm glad that so few of my patients are doctors."

Some nurses also feel that way about it.

★ ★ ★

Lots of people who buy Irish Sweepstakes tickets regularly refuse to purchase Blue Cross.

Evidently they think they are more likely to win money than to get sick.

★ ★ ★

Blue Cross will always be wonderful so long as it gives complete hospital service and pays average costs. I sometimes fear that as it grows to cover the vast majority, the hospitals will have less and less to say in it. When that time arrives hospitals will tend to favor indemnity insurance business and thus get full charges. This would be bad.

This new feature by the director of Lenox Hill Hospital, New York City, will appear as a back-of-the-book column each month in HOSPITALS.

Blue Cross-hospital relationships are those of buyer and seller. When either is dissatisfied there is no sale.

I boldly state that hospitals should be able to determine how many Blue Cross plans there should be in each state. The experimental period is over.

Blue Cross contracts are generally service contracts. That is good medicine. Indemnity plans are not.

★ ★ ★

I would much rather be in a 30-bed acute ward than alone in a private room with a crabby special nurse; and it would cost less.

★ ★ ★

With a five-day, 40-hour week, four weeks' vacation, two weeks' sick time and eight holidays, a worker earning $2,400 per annum gets $1.35 per hour, or 2¼ cents per minute of working time. A great many workmen get more per hour but lose time through strikes, dull periods and inclement weather. There are no "dull" periods in hospitals.

★ ★ ★

Some doctors are like some wives. They're easy to get along with if they think they are having their own way.

★ ★ ★

Many girls study nursing with the idea of thus getting married. We could remove this desire from their minds by putting them in charge of men patients only.

★ ★ ★

We could make more progress in our concerted hospital organizations' efforts if we would use the many talents of a large number of administrators about whom we seldom hear. Usually the fellows who talk the most get the jobs. I know. I've held a lot of posts in my time.

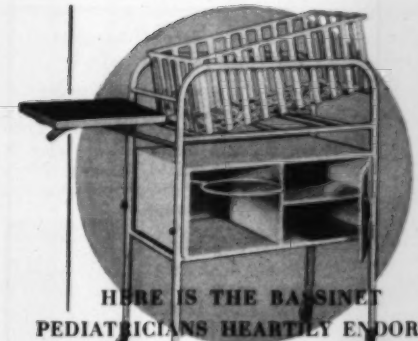
★ ★ ★

I often wonder why, in hospitals today, we give patients so much less whiskey than we did in prohibition days.

★ ★ ★

Some hospital administrators like to go to conventions just to learn how much trouble the other fellows and girls are having. They say it makes them feel better about their own woes.

So long as I am griping about education, I add that, in my opinion, the average hospital administrators' course does not include enough education in business. Hospitals are big business. Trustees



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are often big business men and are apt to be impatient with a hospital manager who does not fully understand costs, balance sheets, etc. The fellow who does not understand accounting is like a poor plumber—he doesn't know how to find leaks.

And I still think we could turn out excellent nurses in two or two and a half years if they were to receive a good part of their didactic training in high schools. They prepare for home economics, business, etc., in high schools. Why not nursing? In addition we would lose fewer of them in the probationary period, as they would be more determined in the choice of a career. We might also avoid the need for government support, as they would have more time for the patients.

OPINIONS

(Continued from page 32)

needed, but some of the factors that should be considered in any study of this problem are as follows:

1. The average occupancy in existing hospitals (broken down by specific classifications, such as pediatrics, obstetrical, surgical and medical).

2. Utilization of existing beds—the number of patients admitted per bed per year. Certainly no community need would be apparent unless existing acute beds were utilized at the rate of approximately 50 patients per bed per year.

3. The number of physicians in the area and the classification of these physicians by specialty.

4. The composition of the population as to occupation, age, number of deaths, number of births, as well as the trend of population in the area for the past as well as estimates for the future.

5. The geographical considerations of the area.

I am satisfied that we have failed, in many sections of the United States, to take advantage of Public Law 725 in providing necessary beds in critical impact areas and have over-built in other areas because we have tried to distribute the money by antiquated formulas.—RITZ E. HEERMAN, *superintendent, The California Hospital, Los Angeles.*

Leave the general hospital bed-ratio formula as it is

I WOULD NOT change the present Hill-Burton formula of 4.5 to 5.5 general hospital beds per 1,000 population. The shortened stay of more hospitalized patients makes it possible for the average hospital bed to serve more patients and, therefore, clearly tends to decrease the number of beds needed. There are, however, "other factors" which at least offset this influence.

MR. BOYD

Some of these are the increasingly inadequate special facilities for the chronically and mentally ill. Our aging population and the "hurly-burly" of modern living are increasing the demand for facilities, but construction of the necessary special facilities falls farther and farther behind the number needed.

The general hospital, consequently, is going to find more and more of these groups arriving on its doorstep as "emergencies," and the community is going to become increasingly dependent on the general hospital for the care of these two groups—the chronically and mentally ill.

As this occurs, the 4.5 to 5.5 general hospital beds primarily for the acutely ill will have to be stretched to provide the 2.0 beds per thousand for the chronics and the 5.9 beds per thousand for the mentally ill that were supposed to have been constructed especially for these two groups under the Hill-Burton Act.

At any rate, why change the Hill-Burton general hospital bed formula until it has had a chance to prove itself? There are relatively few areas where it has been possible to secure enough funds to build the number of beds prescribed in this formula. Not having heard cries of overbuilding from any of these areas, it must be concluded that the 4.5 per thousand formula is still a minimum. Perhaps the figure should be higher, but it is futile to consider raising it until more funds are available for construction under the Hill-Burton program.—ROBERT G. BOYD, *director, Morristown (N. J.) Memorial Hospital.*

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DIRECTORS OF NURSING—(a) Voluntary general hospital, 450 beds; collegiate program, component part, university medical school; East. (b) Chairman, department of nursing; university school, 350 students on campus; preferably one qualified group guidance and overall administrative supervision of educational program; faculty rank; assistant professor. (c) New hospital for children, privately endowed by foundation, currently under construction, August; coast city; pleasant year-round climate. (d) Group of hospitals including new general hospital, fairly large size; M.S. degree advantageous; Pacific Coast. (e) Director, new cancer hospital, unit university group; should know atomic energy nursing, qualified to train nurses in technique of using radio-active isotopes; Master's advantageous. (f) Pediatric unit; large general hospital; seaport city, university center noted for its delightful climate, outside U. S. (g) Nursing service; general hospital; modern well equipped, operated under U. S. auspices; Latin America. (h) Nursing service; general hospital, 300 beds; fashionable resort city, Gulf Coast; minimum $6000. H4-7

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ADMINISTRATORS: (a) Lay; Fairly large general hospital planning addition; desirable town 30,000 near Los Angeles. (b) Lay; 200 bed west-coast hospital to open this fall; require highly qualified man very soon; much sought after location. (c) Medical; large west-coast hospital general in character with Tbc service; requires doctor with medico-administrative experience of at least five years; To $16,000 and attractive furnished residence. (d) Lay; large general voluntary hospital; Chicago area; also administer adjoining old peoples home. (e) Medical; 175 bed general hospital now expanding; one of the most attractive localities in Florida, newly created post. (f) Administrative assistant; 700 bed hospital; east. (g) Lay; 200 bed home for the aged being completed; requires one well trained in social services and experienced in geriatrics and knowledge of orthodox jewish practices; large city; east. (h) Lay; assistant; general, voluntary 250 bed hospital; beautifully situated on Atlantic Ocean near university medical center. (i) Lay; general 125 bed hospital now under construction; desirable county seat town; central. (j) Lay; 140 bed general, voluntary hospital; university city 300,000;

WOODWARD MEDICAL PERSONNEL BUREAU—(Cont'd)

requires two years experience or hospital administrative residency following course in hospital administration.

ADMINISTRATIVE STAFF APPOINTMENTS: (k) Business Manager; prefer woman; highly regarded, eminent group five specialists; complete supervision of practice; staff of ten technical and clerical assistants, plus ten on medical staff; university city 800,000; east. (l) Business Manager; 350 bed university hospital; east. (m) Business Manager; accounting background; 300 bed general voluntary hospital; requires ability in public relations; large coastal city; California. (n) Comptroller; 200 bed general, voluntary hospital; entire charge department; staff of twelve; lovely resort town 60,000; Florida.

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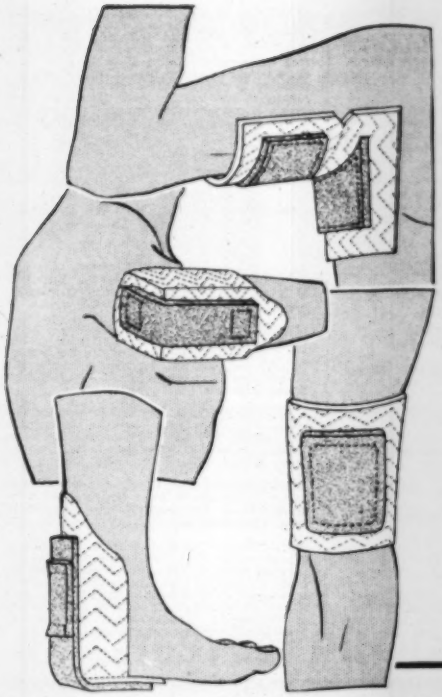

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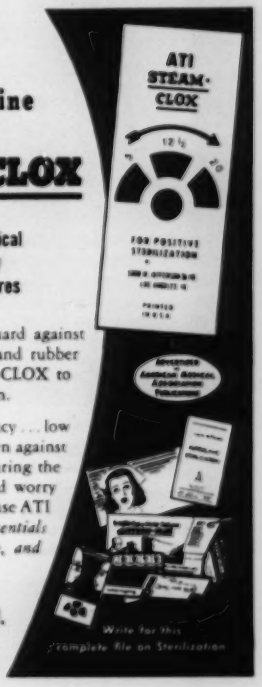

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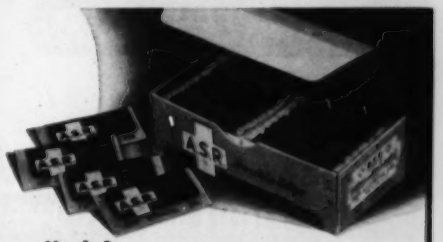

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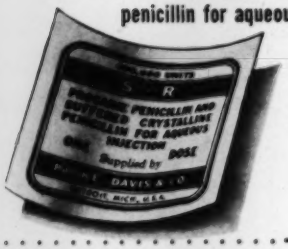

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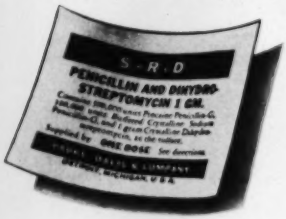

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